

<b>Case Number:</b>	CM14-0161097		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	08/12/2011
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Preventive Medicine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 59-year-old female with a 8/12/11 date of injury. At the time (9/3/14) of request for authorization for motorized cold therapy IF unit, there is documentation of subjective (cervical spine, lumbar spine, left shoulder, left leg, and left middle finger pain) and objective (decreased lumbar spine range of motion, tenderness, spasms, tenderness to palpation to the left upper trapezius and left triceps) findings, current diagnoses (left shoulder impingement, cervical spine disc protrusion, lumbar spine disc protrusion, lumbar spine radiculitis, and left middle finger pain), and treatment to date (activity modification and medications).

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Motorized Cold Therapy IF Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 117-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Polar care (cold therapy unit)

**Decision rationale:** MTUS does not address motorized cold therapy. ODG identifies that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation (ICS) is not recommended. Therefore, based on guidelines and a review of the evidence, the request for motorized cold therapy IF unit is not medically necessary.