

<b>Case Number:</b>	CM14-0218947		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	08/02/2011
<b>Decision Date:</b>	03/05/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

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

The injured worker was a 39 year old female, who sustained an industrial injury, on August 2, 2011. The injured worker suffered a right arm injury, which caused numbness, weakness and a constant sharp stabbing pain in the right arm. The injured worker was diagnosed with right trapezius trigger point, right-sided C4 radiculopathy, rhomboid pain and trapezius muscle strain, right shoulder pain, right shoulder strain/sprain and cervical pain. On December 1, 2014, the range of motion to the right shoulder was flexion of 160 degrees out of 180, extension 40 degrees out of 50 degrees, abduction of 160 degrees out of 180 degrees, addition 40 degrees out of 40, external rotation 90 degrees out of 90 and internal rotation 90 degrees out of 90. Cervical spine range of motion was normal. On November 29, 2014, the progress note the primary physician was doing a right shoulder orthopaedic surgical consultation. November 18, 2014, MRI of the right shoulder was completed, noted a long head bicep tendon anchor tear. The injured worker has undergone functional capacity testing for the right shoulder and neck. The injured worker has had chiropractic services, physical therapy and acupuncture. The injured worker takes medication to relieve symptoms. On October 29, 2014, the primary provider requested cold therapy treatment to manage and reduce pain. On December 3, 2014, the UR denied authorization of a cold therapy unit. The denial was based on the MTUS guidelines which supports the use of cold wraps immediate postoperative use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME Cold Therapy Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain

**Decision rationale:** The Official Disability Guidelines comment on the use of continuous-flow cryotherapy units for the treatment of musculoskeletal pain; to include the shoulder and neck. These guidelines state the following regarding the use of these units: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. In this case the cold therapy treatment is not being used in the immediate postoperative period (i.e. up to 7 days) per the guideline recommendations. The guidelines do not support the use of continuous-flow cryotherapy in any other setting other than the immediate postoperative period. For this reason, the DME Cold Therapy Unit is not considered as a medically necessary treatment.