

Case Number:	CM15-0011698		
Date Assigned:	01/29/2015	Date of Injury:	12/16/2012
Decision Date:	03/23/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/20/2015

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: New York, Tennessee
 Certification(s)/Specialty: Emergency Medicine

CLINICAL CASE SUMMARY

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

This 64 year old male sustained an industrial injury on 12/16/12, with subsequent ongoing neck, left shoulder and bilateral wrist pain. The injured worker underwent right De Quervain release on 11/11/14. Postoperative treatment included chiropractic therapy and medications. In a PR-2 dated 11/24/14, the injured worker complained of right wrist and thumb soreness and ongoing bilateral shoulder pain. Physical exam was remarkable for right wrist with a closed surgical wound consistent with De Quervain release without signs and symptoms of infection, pain upon flexion and extension of the thumb and pain to the right wrist with active range of motion, left shoulder with tenderness to palpation to the left distal clavicle, positive impingement and Hawkin's tests and decreased range of motion. Current diagnoses included bilateral shoulder sprain/strain, left shoulder partial rotator cuff tear, bilateral wrist and cervical spine sprain/strain. The treatment plan included scheduling physical therapy for the right wrist twice a week for four weeks. On 12/29/14, Utilization Review noncertified a request for a cold therapy unit and cold wrap for purchase citing CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit and cold wrap for purchase: 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 Shoulder: Continuous-flow cryotherapy Lumbar and Thoracic, Cold/heat packs

Decision rationale: Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Cold packs are recommended as an option for acute pain. At-home local applications of cold packs are recommended in first few days of acute complaint; thereafter, applications of heat packs or cold packs are recommended. There is minimal evidence supporting the use of cold therapy. While cold packs are useful for low acute pain, there is no recommendation that a Cold unit is necessary to supply the cold applications to the affected area. Sufficient cold can be applied with the use of cold packs, or ice packs. There is no medical necessity for a cold unit. The request should not be authorized.