

Case Number:	CM15-0118447		
Date Assigned:	06/26/2015	Date of Injury:	04/04/2014
Decision Date:	07/28/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/18/2015

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 Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

The injured worker is a 47-year-old female who sustained an industrial injury on 4/4/14 from repetitive motion resulting in right shoulder pain. She was medically evaluated and given medications; x-rays of the right shoulder were performed. She was initially diagnosed with a right shoulder sprain/ strain. She had twelve sessions of physical therapy, two injections into the right shoulder and was referred to a specialist who prescribed further x-rays and an MRI. She returned to work with restrictions. She currently complains of severe constant right shoulder pain (6/10) radiating down into the arm with burning, throbbing, stabbing quality. Her activities of daily living are limited in regards to difficulty with self-care and hygiene, gripping objects, picking up objects, lifting, pushing reaching behind her back. On physical exam of the shoulders there was positive arc sign, impingement testing is positive in Neer's, Hawkins' and Apley's cross-arm, weakness of the rotator cuff musculature, tenderness over both the biceps tendon and long head of the biceps tendon, decreased range of motion. Medications are aspirin, Celexa. Anti-inflammatories were mentioned but not specifically identified with the exception of aspirin. Diagnoses include right shoulder impingement syndrome, unresolved; diabetes; arthritis; rotator cuff tendinosis; right shoulder bursitis; right shoulder pain; right shoulder acromioclavicular joint cartilage disorder; right shoulder most likely bicipital tendinitis. Treatments to date include physical therapy with no improvement; injection (3/2/15) and an undated 2nd injection with no benefit. Diagnostics include MRI of the right shoulder (10/2/14) showing tendinosis, thickening of the distal supraspinatus tendon; right shoulder x-ray (5/14/14) showing limited range of motion, otherwise negative. In the progress note dated 3/2/15 the treating provider's plan of care requests continuous MicroCool machine for ice with supplies post-operatively.

IMR ISSUES, DECISIONS AND RATIONALES

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

Micro cool IFC unit with supplies, unlisted length of use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs. ([http://www. worklossdatainstitute. Verioiponly.com/odgtwc/low_back. htm#SPECT](http://www.worklossdatainstitute.com/Verioiponly.com/odgtwc/low_back.htm#SPECT)).

Decision rationale: There is no evidence to support the need of cold therapy in this patient. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold therapy. There is no controlled studies supporting the use of hot/cold in shoulder pain beyond a short period of time after surgery. The provider have the document the timing and the duration of shoulder cold therapy. Cold therapy is not indicated for chronic pain. Therefore, the request for Micro cool IFC unit with supplies, unlisted length of use is not medically necessary.