

Case Number:	CM15-0118601		
Date Assigned:	06/26/2015	Date of Injury:	01/14/2013
Decision Date:	07/31/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/19/2015

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: California

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:

The injured worker is a 50 year old male, who sustained an industrial injury on 1/14/13. The injured worker has complaints of right shoulder pain; right arm weakness and low back pain. The documentation noted that there is tenderness over the spinous process of the lumbar spine, posterior superior iliac spine (PSIS) bilaterally, S1 (sacroiliac) joints on the right side and over the facet joints. The documentation noted that the FABER (for flexion, abduction, and external rotation) test is positive on the right side and range of motion of the lumbar spine is decreased. The documentation noted that the injured worker had decreased range of motion of the right shoulder. The diagnoses have included low back pain with radiating symptoms to the right lower extremity; right S1 (sacroiliac) joint arthropathy and rule out lumbar spondylosis. Treatment to date has included physical therapy; magnetic resonance imaging (MRI) of the lumbar spine reveals disc protrusion at the level L4-L5 with narrowing of right neuroforamen; compound analgesic cream for symptomatic relief of pain; flexeril for muscle spasms; ultram and norco. The request was for one purchase of motorized cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

One purchase of motorized cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment index, Knee and Leg, Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute and Chronic), Continuous-Flow Cryotherapy.

Decision rationale: MTUS Chronic pain and ACOEM guidelines only have basic recommendation concerning icing area of injury. It does not have details on this device. As per Official Disability Guide(ODG), continuous flow cryotherapy is recommended as a post-surgical option as it may decrease inflammation, pain and swelling. It is not recommended for chronic pain and is not recommended for any body part except for shoulder, wrist, and knees. It is not recommended for the neck or low back. Patient is not post-op and therefore "motorized cold therapy unit" is not medically necessary.