MAXIMUS Federal Services

Case Number:	CM15-0170173		
Date Assigned:	09/10/2015	Date of Injury:	07/26/2013
Decision Date:	10/09/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/28/2015

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: Preventive Medicine, Occupational 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 66 year old male, who sustained an industrial injury on July 26, 2013, resulting in pain or injury to the left foot. Currently, the injured worker reports right shoulder pain, left shoulder pain, neck pain radiating down both upper extremities, and lower back pain. A review of the medical records indicates that the injured worker is undergoing treatment for cervical spine disc herniation with bilateral upper extremity radicular symptoms, right greater than left, bilateral shoulder impingement syndrome with partial right rotator cuff tears with significant loss of range of motion (ROM) bilaterally and motor strength on the right, lumbar disc herniation with bilateral lower extremity radiculopathy, right greater than left, chronic bilateral thumb and wrist arthritis with moderate carpal tunnel syndrome, bilateral plantar fasciitis, and medication induced gastritis. The Primary Treating Physician's report dated July 30, 2015, noted the injured worker's right shoulder pain had steadily worsened over the previous few weeks, with limited his ability to perform his activities of daily living (ADLs). The injured worker was noted to have received authorization to receive arthroscopic surgery to his right shoulder. The right shoulder range of motion (ROM) was noted to be decreased in flexion, abduction, internal rotation, and external rotation. The injured worker's work status was noted to be maximal medical improvement. The treating physician indicates that and electromyography (EMG) study of the bilateral upper extremities in December 30, 2014 revealed right C6 radiculopathy and moderate bilateral carpal tunnel syndrome. A right shoulder MRI from July 21, 2014, was noted to reveal mild impingement syndrome with tendinosis of the rotator cuff

with a partial rotator cuff tear. Prior treatments have included at least 12 sessions of physiotherapy which the injured worker reported as not very beneficial, corticosteroid injections to the left foot helpful for 1.5 months, trigger point injections, corticosteroid injections to the bilateral shoulders, and medications including the current medications of Anaprox, Prilosec, Neurontin, Doral, and Ultracet. The request for authorization dated July 30, 2015, requested purchase of durable medical equipment (DME) of a cold therapy unit pad/wrap purchase with setup and delivery for the right shoulder. The Utilization Review (UR) dated August 11, 2015, modified the request for purchase of durable medical equipment (DME) of a cold therapy unit pad/wrap purchase with setup and delivery for the right shoulder to a rental use of a cold therapy unit for 7 days as there was no evidence provided to support the need for purchase versus rental use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Cold Therapy Unit Pad/Wrap with setup and delivery for the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, 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 Chapter/Cold Compression Therapy Section, Continuous-flow Cryotherapy Section.

Decision rationale: The MTUS Guidelines do not address the use of cold compression therapy for the shoulder. The ODG does not recommend the use of cold compression therapy for the shoulder, as there are no published studies. Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to seven days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. In this case, the use of cold therapy is warranted for the shoulder. However, this is a request for the purchase of a cold therapy unit, which is not supported by the established guidelines. The request for purchase of cold therapy unit pad/wrap with setup and delivery for the right shoulder is not medically necessary.