

Case Number:	CM13-0019956		
Date Assigned:	10/11/2013	Date of Injury:	03/26/2012
Decision Date:	01/17/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiologist has a subspecialty in Pain Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient reported a work related injury on 03/26/2012, specific mechanism of injury not stated. Subsequently, the patient presents for treatment of the following diagnoses, lumbar musculoligamentous sprain/strain with bilateral lower extremity radiculitis, and multilevel 2 mm to 3 mm disc protrusions at L3-4, L4-5, and L5-S1 with central and intervertebral stenosis and facet hypertrophy per MRI scan dated 04/27/2012 with right sacroiliac joint sprain. The clinical note dated 07/08/2013 reports the patient was seen under the care of [REDACTED]. The provider documents a comprehensive orthopedic consultation of the patient. The provider documents he was treating the patient for right shoulder injury, sustained on 02/26/2012. The provider documents the patient is a surgical candidate due to MRI findings on 04/27/2013 which revealed an 80% partial thickness supraspinatus tendon tear, chronic subacromial impingement syndrome, tendinosis of the infraspinatus and high grade partial tear of the subscapularis tendon and osteoarthritis of the glenohumeral joint with chronic tear of the superior labrum. The provider recommended the patient undergo a right shoulder arthroscopic evaluation, decompression, distal clavicle resection, possible coracoplasty, and retro coracoid decompression and rotator cuff repair. The provider recommended postoperatively, a hot/cold therapy unit for the patient to utilize. –

IMR ISSUES, DECISIONS AND RATIONALES

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

The request is for 1 hot/cold 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 (ODG), Knee & Leg (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder and Low Back Chapter.

Decision rationale: The current request is not supported. The clinical documentation submitted for review fails to evidence support for the current request. The provider does not document duration for utilization of this modality postoperatively for the patient's right shoulder injury. California MTUS/ACOEM Guidelines do not specifically address continuous passive hot/cold therapy. Official Disability Guidelines was referenced which indicates postoperatively to shoulder interventions, continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment, post-op use generally up to 7 days. It is unclear if this request is for postoperative to his shoulder, or as per [REDACTED] recommendation on the clinical note dated 07/15/2013, the provider recommends authorization for a thermo 4 unit for pain and muscle spasm control for the patient's lumbar spine. However, Official Disability Guidelines indicate, "Continuous low level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain, the evidence for the application of cold treatment to low back pain is more limited than therapy. In addition, heat therapy is found to be helpful for pain reduction and return to normal function. However, the clinical notes do not evidence whether or not the patient has independently utilized cold/hot applications and the efficacy of treatment for his chronic pain complaints. Given all of the above, the request for 1 hot/cold unit is neither medically necessary nor appropriate.