MAXIMUS Federal Services

Case Number:	CM13-0034557		
Date Assigned:	12/11/2013	Date of Injury:	05/27/2011
Decision Date:	05/16/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	10/15/2013

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Florida. 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/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 was injured on 5/27/2011. The diagnoses are right shoulder pain, low back pain and insomnia. An MRI of the right shoulder showed acromio-clavicular arthropathy, subacromial bursa and supraspinatus tendon tear. The lumbar spine MRI showed degenerative disc disease. The medications listed are tramadol and naproxen for pain, Flexeril for muscle spasm and Prilosec for the prevention and treatment of NSAID induced gastritis. The patient is being treated for co-existing diabetes with metformin and glipizide. Following an evaluation by [redacted] on 7/17/2013, Norco was added and shoulder arthroscopy with subacromial decompression was planned to manage the worsening shoulder pain. A Utilization Review decision was rendered on 9/16/2013 recommending non certification of purchase of Portable Cold/Heat for right shoulder

IMR ISSUES, DECISIONS AND RATIONALES

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

PORTABLE COLD/HEAT FOR RIGHT SHOULDER (PURCHASE): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 555-556.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: The CA MTUS addressed the use of cold/heat therapy in the treatment of shoulder pain. The ODG also have extensive guidelines on the use of cold/heat therapy in the treatment of shoulder pain. There is potential beneficial effects when an initial few days of cold application is followed by continous -flow heat cryotherapy in the post operative period following extensive shoulder surgery. The record indicate that the patient is scheduled for physical therapy X3 a week for 2 weeks. A right shoulder surgery is being planned by [redacted]. The indication to purchse a Cold/Heat cryotherapy is unclear as there is lack of documentation on post physical therapy evaluation or post surgical cryotherapy requirement.