

<b>Case Number:</b>	CM13-0071582		
<b>Date Assigned:</b>	05/14/2014	<b>Date of Injury:</b>	09/10/2013
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/27/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 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 is a 62 year old male who was injured on 9/10/2013. The listed diagnoses are contusion of the shoulder and closed fracture acromion, other affections of shoulder, unspecified derangement of the joint shoulder. The 11/20/2013 and 11/06/2006 reports indicate "no show." A 10/30/2013 report is the primary treating physician's initial comprehensive medical reporting with the presenting complaints of left shoulder pain, status post work injury from 09/10/2013, constant low back pain with radiation down the right lower extremity, on and off neck pain, right shoulder pain on and off, on and off numbness involving right hand. Listed impressions on this report were left shoulder pain impingement, blunt trauma history of fractured left acromion, and possible lumbar discogenic pain, right lumbosacral radicular pain on and off at L5-S1, and possible cervical discogenic pain. Treatment recommendations include chiropractic therapy, home TENS unit for trial of 2 months, listed medications include Anaprox, Flexeril, Ultram, Ultracin topical cream. This request was denied by Utilization Review letter 11/27/2013 and a telephone conversation took place with the treating physician and utilization reviewer which talked about the motorized heat modality over the conventional hot packs.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PURCHASE OF THERMAPHORE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 156, 157. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-twc guidelines has the following regarding heat therapy:([http://www.odg-twc.com/odgtwc/low\\_back.htm#TreatmentPlanning](http://www.odg-twc.com/odgtwc/low_back.htm#TreatmentPlanning)).

**Decision rationale:** The Official Disability Guidelines (ODG) Guidelines do support heat/cold therapy and particularly for heat therapy for chronic pain. However, MTUS/ACOEM Guidelines state that at-home application of heat and cold are just as effective as other means. ODG Guidelines also support at-home application of heat packs. Furthermore, there is lack of guidelines support for motorized, sophisticated heat delivery system. Therefore, the request for purchase of Thermaphore is not medically necessary and appropriate.