

Case Number:	CM14-0016714		
Date Assigned:	04/11/2014	Date of Injury:	07/16/2013
Decision Date:	05/28/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	02/10/2014

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 & Rehabilitation 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 was injured on 07/16/2013. He fell off from the roof head first, injuring his head and shoulder. He sustained a fracture to his clavicle. PR2 dated 01/09/2014 reports the patient presents with complaints of inflammation and swelling in his post left shoulder. On exam, there is decreased range of motion in the left shoulder by 25% in all range of motions. The patient is diagnosed with partial tear of the left shoulder; status post left clavicle fracture; and thoracic sprain/strain. Treatment and plan is follow-up with [REDACTED]; continue shock wave therapy; x-ray of the left shoulder; ThermaCooler; continue cream; and rehab kits for the left shoulder. On authorization request form dated 01/07/2014, DME is requested for the patient; Demand is made for an immediate decision of recommended treatment including ThermaCooler system, ThermaCooler Pad/Wrap and set up and delivery.

IMR ISSUES, DECISIONS AND RATIONALES

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

THE REQUEST FOR DME - THERMOCOOLING SYSTEM (HOT/COLD COMPRESSION THERAPY): 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), Rotator Cuff Syndrome (DME).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous-flow cryotherapy.

Decision rationale: According to the Official Disability Guidelines, short term rental of a continuous cryotherapy device is recommended as an option after surgery, but not for nonsurgical treatment. The requested device is not supported by the evidence-based guidelines. There is inadequate clinical evidence to substantiate that hot-cold unit is more efficacious than standard ice/cold and hot packs. The references state mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. Simple at home applications of heat and cold are thought to suffice for delivery of heat or cold therapy. According to the guidelines, at-home local applications of cold packs first few days of acute complaints; thereafter, applications of heat packs are recommended. Simple at home applications of heat and cold can suffice for delivery of heat or cold therapy. Therefore, the request for DME-Thermocooling System (Hot/Cold Compression Therapy is not medical necessary and appropriate.