

Case Number:	CM14-0064529		
Date Assigned:	07/11/2014	Date of Injury:	05/25/2010
Decision Date:	09/16/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	05/07/2014

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 Internal Medicine and is licensed to practice in Arizona. 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 complainant is a 31-year-old female who has bilateral shoulder pain and hand pain secondary to long-term repetitive carrying of heavy food trays while working as a waitress. The official date of injury is May 25, 2010. Her diagnoses include right shoulder tendinitis, left shoulder full-thickness tear of the rotator cuff and left shoulder impingement with an intra-substance tear confirmed by an April 9, 2013 MRI. She did undergo bilateral carpal tunnel repairs in 2013 which provided some relief- but, really did not take care of her main symptoms. On March 27, 2014, the orthopedic surgeon performed a left shoulder arthroscopic subacromial decompression with acromioplasty, major synovectomy and a distal clavicle resection. The orthopedist's pre-operation note indicated that she should have a Hot/Cold Contrast Unit and defined it as a multi-modality treatment unit that applies ice and heat packs with an additional benefit of compression. It improves compliance and helps regulate temperature to prevent over icing or overheating thus reducing the possibility of causing tissue damage and delaying functional restoration. The authorization request is for Cold Therapy with pad for the left shoulder. This is nearly synonymous with the Hot/Cold Contrast Unit with a Compression Pad that was described by the Orthopedic Surgeon prior to the patient shoulder surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase cold therapy with pad left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints Page(s): 44; 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Integrated Treatment/Disability Duration Guidelines, Shoulder Disorders, "Continuous FlowCryotherapy".

Decision rationale: The MTUS, weakly suggests that home cold packs alternating with heat can be beneficial to the shoulder. The Official Disability Guidelines indicates that Continuous Flow Cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Post-operative use generally may be up to 7 days, including home use. In the postoperative setting, Continuous Flow Cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on lower frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. Continuation Flow Cryotherapy Units provide regulated temperatures through the use of power to circulate ice water in the cooling packs. The Hot/Cold Unit was previously not certified apparently because inadequate documentation had been provided. The reviewing physician stated that the surgical history had not been provided. As stated in the above patient history, the operative note was provided along with a discussion by the Orthopedist of why he felt this patient would benefit from The Hot/Cold Contrast Unit after the arthroscopic surgery. Under this circumstance, I believe the patient now meets the criteria for certification. It is not the responsibility of this reviewer to know the cost of a rental versus the cost of purchasing the Hot/Cold Unit; but, I do state that the patient meets the criteria as delineated by the ODG; and thus, this service is medically necessary.