

Case Number:	CM14-0086276		
Date Assigned:	07/23/2014	Date of Injury:	05/02/2012
Decision Date:	09/18/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/09/2014

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 and Rehabilitation and Pain Management, 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 58-year-old male with a date of injury of 05/02/2012. The listed diagnoses per the treating physician are: lumbar spine/strain with radiculopathy, lumbar spine disk desiccation, lumbar spine hemangioma, right shoulder sprain/strain, right shoulder impingement, right shoulder osteoarthritis, right shoulder tendinosis, right shoulder labral tear, right shoulder effusion, myospasm and gastritis. According to progress, report 05/08/2014, the patient presents with low back and right shoulder pain. He states his pain in the lower back is more on the right side and sometimes radiates to the right groin. He also is experiencing pain in his right shoulder, which is sharp and throbbing with an intensity of 4-8/10. Examination of the shoulder revealed decreased range of motion and tenderness over the superior border of trapezius muscle on the right side. Examination of the lumbar spine revealed decreased range of motion and tenderness over the L4-L5 and L5-S1 facet area, mainly on the right side. The treating physician is requesting a hot and cold wrap (VascuTherm). He states cold therapy is the preferred drug-free method to treat acute injury where swelling persists in the acute stages of inflammation and heat therapy is to provide pain relief, reduction of muscle spasm, and increase of local blood flow. Utilization review denied the request on 05/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot and Cold Pack with Wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines has the following: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative 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 more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. (Hubbard, 2004) (Morsi, 2002) (Barber, 2000) The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. (BlueCross BlueShield, 2005) This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of knee surgery. (Raynor, 2005) There is limited information to support active vs passive cryo units. Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. (Aetna, 2006) See also Cold/heat packs.

Decision rationale: This patient presents with low back and right shoulder pain. The treating physician is requesting a multi-modality hot and cold pack with wrap (VascuTherm). The treating physician states the cold therapy, heat therapy, and compression therapy is a reliable method to treat swelling and inflammation and provide pain relief and reduce edema. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative 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 use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated. This patient is not status post surgery and ODG does not recommend continuous-flow cryotherapy for nonsurgical treatment. As such, the request is not medically necessary.