

Case Number:	CM14-0204694		
Date Assigned:	12/17/2014	Date of Injury:	03/11/2014
Decision Date:	02/09/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/08/2014

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 Occupational 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 injured worker is a 60 year old male with date of injury 3/11/2014. He was in the usual course of his duties when he lifted a tire and performed some lifting and twisting motions and felt a pop in his shoulder. He has had pain in his shoulder since then. MRI done on 4/16/2014 revealed massive retracted rotator cuff tear including subscapularis, supraspinatus, and infraspinatus. The tendon is retracted proximal to the glenohumeral joint associated with muscle atrophy, long head of the biceps is torn and scarred in the bicipital groove, there is degenerative changes of the glenohumeral joint with humerus osteophytosis and moderate effusion and synovitis. Physical exam done 5/13/2014 showed left shoulder elevation 150, right 160. External rotation is 30 on the left and 50 on the right, internal rotation is L3 left, L1 right, he has tenderness to palpation over the greater tuberosity which is worse in the biceps tendon, no significant Neer or Hawkins impingement signs, reduced strength is both supra and infraspinatus, subscapularis is normal. He was treated conservatively till 11/25/14 when he was worked up for arthroscopic surgery of the left shoulder. The decision is for Hot/Cold therapy and wrap. UR dated 11/26/14 was modified certified for 17 days use of cryotherapy unit and wrap.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold therapy unit and wrap: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder; continuous flow cryotherapy

Decision rationale: The MTUS does not specifically address the use of heat or cold therapy pre or post operatively therefore other guidelines were consulted. Heat /cold therapy is a passive modality of physical medicine and is recommended to provide short term relief during the early phases of pain treatment to reduce pain, swelling and inflammation and improve rate of healing of soft tissues and can be used with active therapy. Per the ODG, cold therapy unit is 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. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs, based on the injured workers clinical picture and the guideline recommendation hot/cold therapy unit and wrap is medically necessary.