

Case Number:	CM15-0101635		
Date Assigned:	06/04/2015	Date of Injury:	06/02/2014
Decision Date:	07/03/2015	UR Denial Date:	05/16/2015
Priority:	Standard	Application Received:	05/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 (IW) is a 47-year-old male who sustained an industrial injury on 06/02/2014. He reported pain in the right shoulder. The injured worker was diagnosed as having right shoulder rotator cuff tear, subacromial bursitis, impingement syndrome, and adhesive capsulitis. Treatment to date has included physical therapy, anti-inflammatories, cortisone injections, activity modification, rest, and MRI, which revealed a full-thickness rotator cuff tear. Currently, the injured worker had a right shoulder arthroscopy, limited glenohumeral debridement and capsular release/lysis of adhesions, subacromial decompression bursectomy and arthroscopic rotator cuff repair on 01/30/2015. Examination under anesthesia revealed full passive range of motion under anesthesia to 170 degrees of forward flexion and 80 degrees of external rotation. A request for authorization was received on 04/21/2015 for Retrospective purchase of water circulating cold pad with pump for the right shoulder (DOS 1/30/15).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective purchase of water circulating cold pad with pump for the right shoulder (DOS 1/30/15): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.?(http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT).

Decision rationale: According to ODG guidelines, cold therapy is "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel". Hot and Cold therapy is usually approved for 7 days during the acute post op setting to treat post op inflammatory swelling. Therefore, the retrospective request for purchase of water circulating cold pad with pump for the right shoulder is not medically necessary.