

Case Number:	CM15-0080367		
Date Assigned:	05/01/2015	Date of Injury:	07/02/2010
Decision Date:	06/10/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/27/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 63 year old female, who sustained an industrial injury on July 2, 2010. She reported lifting a box from the floor that started to slip, with all the weight on her left hand resulting in immediate severe pain in the left hand, left wrist radiating up to the arm, pain in the shoulder, and pain in the left side of her neck. The injured worker was diagnosed as having left shoulder impingement syndrome/SLAP tear/tendinitis/cuff tear/positive MRI/status post shoulder injections times three, status post left carpal tunnel release, status post left wrist arthroscopic surgery, possible reflex sympathetic dystrophy of the left arm, symptoms of anxiety and depression, and symptoms of insomnia. Treatment to date has included left carpal tunnel release, nerve conduction study (NCS)/electromyography (EMG), left wrist scope, MRI, physical therapy, and medication. Currently, the injured worker complains of pain in her coccyx and pain in the left shoulder region. The Primary Treating Physician's report dated February 13, 2015, noted the injured worker rated her pain as an 8/10 on the visual analog scale (VAS). The left shoulder examination was noted to show tenderness over the greater tuberosity of the left humerus, a positive impingement test, subacromial grinding and clicking of the left humerus, and tenderness over the rotator cuff muscles. The treatment plan was noted to include pending authorization for left shoulder arthroscopic scope cuff repair, a bone scan, and electromyography (EMG)/nerve conduction velocity (NCV) studies of the upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot and cold unit: 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) Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous-flow cryotherapy.

Decision rationale: Based on the 02/13/15 progress report provided by treating physician, the patient presents with left shoulder pain. The request is for HOT AND COLD UNIT. No RFA provided. Patient's diagnosis on 10/27/14 and 02/13/15 included possible reflex sympathetic dystrophy of the left arm, left shoulder impingement syndrome, SLAP tear, tendinitis, cuff tear, positive MRI, status post shoulder injection x3. Physical examination to the left shoulder on 02/13/15 revealed tenderness over the rotator cuff muscles, and greater tuberosity of left humerus, with subacromial grinding and clicking. Positive Impingement test. Treatment to date has included left carpal tunnel release, electrodiagnostic studies, left wrist scope, MRI, physical therapy, and medication. The patient is permanent and stationary, per 02/13/15 progress report. Treatment reports were provided from 10/27/14 - 02/13/15. The MTUS and ACOEM Guidelines are silent with regards to this request. ODG-TWC, Shoulder Chapter under Continuous-flow cryotherapy states: 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. Per 10/27/14 progress report, treater states "I am requesting authorization for a left shoulder scope arthroscopic surgery, rotator cuff repair. Recommending the following devices for home use to help the patient recover from their surgical procedure. Hot/Cold Contrast unit is a multi-modality treatment that is preferred over simple ice and heat packs for the additional benefits of compression as well as increased patient compliancy and the regulation of temperature to prevent over icing or over heating which can cause tissue damage and delays in functional restoration." ODG Guidelines do support this type of device for postoperative recovery. However, treater has not indicated that unit is to be used postoperatively for 7 days, as recommended by guidelines. While ODG guidelines support at-home application of cold/heat, treater's intent is for home use of this device, which would still not be indicated, as the use of an ice bag would suffice. Furthermore, there is no documentation that patient has been authorized for surgical procedure to left shoulder. Therefore, the request IS NOT medically necessary.