

Case Number:	CM15-0063639		
Date Assigned:	04/09/2015	Date of Injury:	01/13/2013
Decision Date:	05/12/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	04/03/2015

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, Michigan, 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 is a 47-year-old, female who sustained a work related injury on 1/13/13. She tripped and fell injuring left shoulder. The diagnoses have included persistent left shoulder impingement syndrome and distal clavicle arthrosis. Treatments have included an MRI of the left shoulder, physical therapy, medications, acupuncture, left shoulder subacromial cortisone injections and home exercises. In the Initial Comprehensive Orthopedic Consultation Report dated 2/18/15, the injured worker complains of moderate, constant, dull, intermittent sharp left shoulder pain. The left shoulder has been unresponsive to conservative treatments. The treatment plan is to request authorization for left shoulder surgery. The requested treatments are for a cold therapy unit and a continuous passive movement machine to use postoperatively.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) 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". There is no evidence to support the efficacy of hot and cold therapy in this patient. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold therapy. There is no controlled study supporting the use of hot/cold therapy in shoulder complaints or post op pain beyond 7 days after surgery. There is no documentation that the patient needs cold therapy. Therefore, the request for Cold therapy unit is not medically necessary.

Continuous passive motion machine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-213.

Decision rationale: According to MTUS guidelines, there is no strong evidence supporting the use of continuous passive motion for the treatment of post op shoulder pain. (ACOEM 212-213 TABLE 9-6). Therefore, the request for Continuous passive motion machine is not medically necessary.