

Case Number:	CM15-0095756		
Date Assigned:	05/22/2015	Date of Injury:	09/25/2013
Decision Date:	06/29/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/18/2015

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 59 year old female, who sustained an industrial injury on September 25, 2013. She reported falling and injuring her left shoulder. The injured worker was diagnosed as having other affections of shoulder region not elsewhere classified and left shoulder impingement secondary to fracture of the greater tuberosity and fracture dislocation of the left shoulder. Diagnostic studies to date have included MRIs, x-rays, a bone density scan, and arthrography. Treatment to date has included a sling, a home exercise program, work modifications, physical therapy, and medications including oral pain, topical, muscle relaxant, and non-steroidal anti-inflammatory. On February 25, 2015, the injured worker complains of continued left shoulder pain and limited range of motion. The physical exam revealed tenderness over the acromioclavicular joint and subacromial space, positive impingement tests, posterior drop arm test, decreased strength, and neurologically intact. The treatment plan includes a left shoulder scope and rotator cuff repair. The requested treatment is a hot/cold therapy unit with pad.

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 Pad/wrap purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter, Continuous-flow cryotherapy.

Decision rationale: The patient presents with left shoulder pain. The request is for HOT/COLD THERAPY UNIT AND PAD/WRAP PURCHASE. MRI of the upper extremity joint, 04/24/14, shows moderate to severe glenohumeral joint osteoarthritis with high-grade full-thickness cartilage loss at the anterior and anterior/inferior glenoid. Physical examination of the shoulder reveals tenderness over the AC joint and over subacromial space. Range of motion is limited due to pain. Hawkins and Neers impingement are positive. Supraspinatus and arm drop test are positive. Patient's medication include Norco. Per progress report dated 04/08/15, the patient is temporarily totally disabled. 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." Treater does not discuss this request. In this case, it appears the treater is recommending a Hot/Cold Therapy Unit for home use to help the patient recover from a surgical procedure. Per progress report dated 04/08/15, treater notes "Patient is here for ROM exam and to discuss possible surgery. She is indicated for L shoulder RTC repair. Will get her scheduled. Needs clearance." ODG supports the use of Hot/Cold Therapy Unit for postoperative recovery. However, treater does not indicate postoperative use of the Hot/Cold Therapy Unit for no more than 7 days, as recommended by ODG. Furthermore, there is no documentation that patient has been authorized for a shoulder surgical procedure. Therefore, the request IS NOT medically necessary.