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| Case Number: | CM14-0015987 | | |
| Date Assigned: | 06/04/2014 | Date of Injury: | 02/05/2011 |
| Decision Date: | 07/29/2014 | UR Denial Date: | 01/29/2014 |
| Priority: | Standard | Application Received: | 02/07/2014 |

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 Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 50-year-old female with a reported injury on 02/05/2011. The mechanism of injury was not provided within the clinical notes. The clinical note dated 01/30/2014 reported that the injured worker complained of left shoulder pain. The physical examination revealed the injured worker's left shoulder range of motion demonstrated active forward flexion to 120 degrees, extension to 30 degrees, adduction to 20 degrees, abduction to 120 degrees, and external and internal rotation to 50 degrees. It was reported that the injured worker had a well-healed surgical incision. The injured worker's diagnoses included status post arthroscopic subacromial decompression of the left shoulder on 12/10/2013. The injured worker's medication regimen was not provided within the clinical notes. The provider requested purchase of half arm wrap, universal therapy wrap with rental of Q-Tech cold therapy system, and shoulder continuous passive motion (CPM) unit with pad for 30 days; the rationales were not provided within the clinical documentation. The request for authorization was submitted on 02/06/2014. The injured worker's prior treatments included 12 physical therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

SHOULDER CONTINUOUS PASSIVE MOTION (CPM) UNIT WITH PADS FOR 30 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

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

Decision rationale: The request for shoulder continuous passive motion (CPM) unit with pads for 30 days is non-certified. The injured worker complained of left shoulder pain. The treating physician's rationale for the CPM unit was not provided within the clinical notes. The Official Disability Guidelines do not recommend continuous passive motion (CPM) for shoulder rotator cuff problems, but they are recommended as an option for adhesive capsulitis, up to 4 weeks, 5 days per week. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition was not provided; there is a lack of documentation indicating that the injured worker has significant functional deficits to the shoulder required a CPM device. Moreover, there is not enough clinical evidence indicating the injured worker has adhesive capsulitis as an active diagnosis indicating the utilization for a CPM device. Given the information provided, there is not enough evidence to determine the appropriateness of this CPM to the shoulder to warrant medical necessity; as such, the request is non-certified.

PURCHASE OF HALF ARM WRAP AND UNIVERSAL THERAPY WRAP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Cold compression therapy, Game Ready accelerated recovery system, & Continuous-flow cryotherapy.

Decision rationale: The request for purchase of half arm and universal therapy wrap is not medically necessary. The injured worker complained of left shoulder. The treating physician's rationale for a universal therapy wrap was not provided within the clinical notes. The Official Disability Guidelines do not recommend cold compression therapy in the shoulder as there are no published studies. The guidelines recommend Game Ready accelerated recovery system as an option after surgery, but not for nonsurgical treatment. The guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The request for the rental Q-Tech cold therapy system is not medically necessary; therefore, the request for the half arm wrap and universal therapy wrap is not medically necessary.

RENTAL Q-TECH COLD THERAPY SYSTEM WITH WRAP X 35 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

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

compression therapy, Game Ready accelerated recovery system, & Continuous-flow cryotherapy.

Decision rationale: The request for the rental Q-Tech cold therapy system with wrap x35 days is not medically necessary. The injured worker complained of left shoulder pain. The treating physician's rationale for the cold therapy session was not provided within the clinical notes. The Official Disability Guidelines do not recommend cold compression therapy in the shoulder, as there are no published studies. The guidelines recommend Game Ready accelerated recovery system as an option after surgery, but not for nonsurgical treatment. The guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Per the guidelines, cold compression therapy to the shoulder is not recommended for nonsurgical treatment or postoperatively past 7 days given, the information provided, there is not enough evidence to determine the appropriateness of cold therapy to warrant medical necessity. Therefore, the request is not medically necessary.