

Case Number:	CM14-0118082		
Date Assigned:	08/06/2014	Date of Injury:	05/25/2005
Decision Date:	10/03/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/25/2014

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 Family Medicine 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:

This is a male patient who reported an industrial injury on 5/25/2005, over nine (9) years ago, attributed to the performance of his usual and customary job tasks. The patient complains of chronic pain in the right and left shoulders, right and left hips, and the right foot. The patient underwent recent surgical intervention to the left hip reported as a greater trochanteric bursitis to me and bone spur removal from the greater trochanteric done on 7/18/2014. The patient was in a brace with crutches. The objective findings on examination included no acute distress; decreased range of motion of the right shoulder secondary to pain; positive tenderness of the lateral acromion; positive crepitus with range of motion; left shoulder with decreased range of motion secondary to pain; positive crepitus with range of motion to my: positive tenderness over the acromioclavicular (AC) joint; left hip is in a brace. The patient was prescribed Norco 10/325 mg #45; and Cymbalta 60 mg #60. The treatment plan included injections to the shoulder; Klonopin; Restoril. The patient is noted to be status post two hip replacements in the left hip, status post two shoulder rotator cuff repair procedures; status post bilateral carpal tunnel repair both hands; and status post bilateral tendinitis repair. The patient was ordered Vascutherm with DVT prevention and an intermittent hot cold compression unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascu therm with deep vein thrombosis (DVT) prevention: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Disability Duration Guidelines/Work Loss Data institute

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 300, 338. Decision based on Non-MTUS Citation (ODG) Knee and leg chapter cold heat packs; continuous flow cryotherpay; Low back chapter cold/head packs

Decision rationale: There is no demonstrated medical necessity for the provision of the Vascutherm DVT prevention system; universal therapy wrap purchase. There is no demonstrated medical necessity for compression therapy post operatively for the prevention of DVT. The patient is noted to have had an initial DVT screening; however, there are no documented issues in the medical history of this patient to establish an increased risk for DVT in this patient in relation to the carpal tunnel release (CTR)/tenosynovectomy. There is no rationale provided to support the medical necessity of the pneumatic compression devise over compression stockings or wrap for the hip procedure. The Motorized hot/cold therapy unit and Vascutherm DVT prevention system with a wrap is not medically necessary for the treatment of postoperative pain to the hip and alternatives for treatment of the hip are readily available. The request for authorization of the Motorized hot/cold Unit with circulating pads and DVT compression is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the motorized hot/cold unit as opposed to the more conventional methods for the application of heat or cold. The concurrent application of intermittent compression to prevent DVT is not demonstrated be medically necessary for the performed procedure. The requesting provider failed to provide a rationale supported with objective evidence to support medical necessity.

Intermittent Hot/Cold Compression Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Disability Duration Guidelines/Work Loss Data institute

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 300, 338. Decision based on Non-MTUS Citation ODG) Knee and leg chapter cold heat packs; continuous flow cryotherpay; Low back chapter cold/head packs

Decision rationale: The request for the Motorized hot/cold system or Recovery System for home use is not supported with objective evidence that demonstrates medical necessity and is inconsistent with the recommendations of the CA MTUS for the treatment of the post-operative hip. There is no demonstrated medical necessity for the Motorized hot/cold unit over the recommended cold packs or hot packs. The motorized hot/cold unit is not demonstrated to be medically necessary for home use post operatively. The Motorized hot/cold therapy unit is not medically necessary for the treatment of postoperative pain to the hip and alternatives for treatment of the hip are readily available. The request for authorization of the Motorized hot/cold Unit with circulating pads is not supported with objective medically based evidence to support medical necessity. There is no provided objective medically based evidence to support the

medical necessity of the motorized hot/cold unit as opposed to the more conventional methods for the application of heat or cold. The CA MTUS, the ACOEM Guidelines, and the ODG recommend hot or cold packs for the application of therapeutic cold or heat. The use of hot or cold is not generally considered body part specific. The Official Disability Guidelines chapter on the knee and lower back states a good example of general use for hot or cold. The issue related to the request for authorization is whether an elaborate mechanical devise is necessary as opposed to the recommended hot or cold pack. The issue is not the body part to be treated, but the method of application of heat or cold. It is used as an example that the hot or cold packs are used for treatment and not the mechanical devise in addition to the provided guidelines for the hip. There is no demonstrated medical necessity for the requested cold unit with wrap for the postoperative treatment of the hip. There was no rationale supported by objective evidence provided by the requesting physician to support the medical necessity of the cold unit with intermittent compression.