MAXIMUS Federal Services

Case Number:	CM14-0171456		
Date Assigned:	10/23/2014	Date of Injury:	08/30/2010
Decision Date:	11/25/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/16/2014

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 Orthopedic Surgery 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 49-year-old female sustained an industrial injury on 8/30/10. Injury was reported to the right shoulder, upper back, and lower back while pulling a pallet of bakery items. She underwent right shoulder paralabral cyst and subscapularis tendon debridement and SLAP tear repair on 1/27/12. The 6/24/14 treating physician report cited persistent moderate right shoulder pain. Physical exam documented slight tenderness over the medial scapula and scapulothoracic bursa, and tenderness over the acromioclavicular joint, subscapularis and biceps tendon. Range of motion was abduction 150, forward flexion 150, and external rotation 40 degrees, with internal rotation on L1. There were positive cross arm, Yergason's, Speed's, and impingement tests. Motor sensory exam was normal. The treatment plan recommended right shoulder surgery. Right shoulder re-do arthroscopy with extensive debridement of the subscapularis, infraspinatus, and anterior and posterior labrum, biceps tenodesis, subacromial decompression, and distal clavicle excision was performed on 7/15/14. An 8/16/14 request for authorization was submitted for fourteen day rental for one VascuTherm cold therapy and purchase of compression therapy pad to right shoulder. The 9/26/14 utilization review modified the retrospective request for 14 day rental of a VascuTherm cold therapy unit to a 7-day rental including purchase of the compression pad consistent with guideline criteria for continuous flow cryotherapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: retrospective on or after 7/8/2014 fourteen day rental for one vascutherm cold therapy and purchase of compression of compression therapy pad to right shoulder.: 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)

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 flow cryotherapy, Cold compression therapy

Decision rationale: The California MTUS is silent regarding cold compression devices. The Official Disability Guidelines state that cold compression therapy is not recommended in the shoulder. Guidelines generally support the use of continuous flow cryotherapy for up to 7 days following shoulder surgery. Guidelines state that there has been a randomized controlled trial since 2008 to evaluate and compare clinical post-operative outcomes for patients using an active cooling and compression device, and those using ice bags and elastic wrap after acromioplasty or arthroscopic rotator cuff repair, but the results are not available. The 9/26/14 utilization review decision recommended partial certification of this device for 7-day use and approved purchase of the compression pad. There is no compelling reason in the records reviewed to support the medical necessity of this device beyond the 7-day rental previously certified. Therefore, this request is not medically necessary