

Case Number:	CM14-0191954		
Date Assigned:	11/25/2014	Date of Injury:	06/20/2008
Decision Date:	01/12/2015	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/17/2014

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 Hand Surgery, and is licensed to practice in Texas. 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 56-year-old male who reported an injury on 06/20/2008. The mechanism of injury was reportedly a whiplash type injury from a motor vehicle accident. His diagnoses included lumbago and cervicalgia. His past treatments included surgery, unspecified medications, and injections. Diagnostic studies include an MRI of the right ankle performed on 09/15/2009, an MRI of the right shoulder performed on 02/27/2010, and an MRI of the left shoulder performed on 04/04/2014, which revealed rotator cuff tendinitis, rotator cuff interval disease, and biceps tenosynovitis. His surgical history included an anterior cervical discectomy, cervical total disc replacement, and fusion of the C3-7 in 2009, right knee surgery performed on 12/16/2011 and left knee surgery performed on 09/21/2012. The documentation dated 08/07/2014 indicated the injured worker complained of persistent symptoms to the left shoulder following previous right shoulder diagnostic and operative arthroscopy. It was noted that the injured worker reported excellent results from the right shoulder surgery and wanted to proceed with left shoulder diagnostic and operative arthroscopy. The physical examination of the right shoulder revealed limited range of motion in flexion and abduction to 150 degrees. Muscle weakness was rated 4/5 in all planes. The left shoulder examination revealed limited range of motion in flexion and abduction to 150 degrees with positive Neer's and Hawkins' impingement signs and pain with empty can testing. The progress note dated 09/25/2014 indicated the injured worker complained of constant low back pain with radiation to the lower extremities rated 8/10. He also complained of cervical or neck pain with radiation to the upper extremities rated 4/10. The physical examination of the cervical spine revealed tenderness to palpation over the paravertebral muscle with spasm. It was noted that range of motion was limited with pain; however, sensation and strength were normal. The physical examination of the lumbar spine revealed tenderness to palpation of the paravertebral muscle with guarded and restricted range of

motion with standing flexion and extension. The injured worker's strength was rated 4/5. Current medications were not specified. The treatment plan included refills of unspecified medications and a request for a lumbar discogram. The request was for continuous passive motion x14 day rental, a sheepskin pad purchase, VascuTherm cold compression x14 day rental, and a cold therapy wrap/pad purchase. The rationale for the request was not indicated; however, the Request for Authorization form dated 09/18/2014 was included for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder CPM (Continuous passive motion) x 14 Day Rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines TWC (Treatment in Workers Compensation), Shoulder Procedure Summary Blue Cross of California Medical Policy # DME.00019: Continuous Passive Motion Devices

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 CPM (Continuous passive motion) x 14 Day Rental is not medically necessary. The Official Disability Guidelines do not recommend continuous passive motion for shoulder rotator cuff problems, but it is recommended as an option for adhesive capsulitis up to 4 weeks/5 days per week. The clinical documentation provided indicated the injured worker had shoulder symptoms related to his rotator cuff including rotator cuff tendinitis. As the guidelines do not recommend continuous passive motion for shoulder rotator cuff problems, the request for Shoulder CPM (Continuous passive motion) x 14 Day Rental is not medically necessary.

Sheepskin Pad Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines TWC (Treatment in Workers Compensation), Shoulder Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the primary request for Shoulder CPM (Continuous passive motion) is not medically necessary, the request associated with the service is also not supported.

Vascutherm Cold Compression x 14 Day Rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines TWC (Treatment In Workers Compensation), Shoulder Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Cold compression therapy

Decision rationale: The request for Vascutherm Cold Compression x 14 Day Rental is not medically necessary. The California ACOEM Guidelines indicate that a patient's at home application of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. More specifically, however, the Official Disability Guidelines do not recommend cold compression therapy for the shoulder as there are no published studies. It may, however, be an option for other body parts. The documentation submitted for review failed to indicate which area the cold compression treatment would be used for. The documentation also failed to provide a clear rationale as to the medical necessity for a compression device. Based on the clinical information submitted for review and using the evidence based, peer reviewed guidelines referenced, the request for Vascutherm Cold Compression x 14 Day Rental is not medically necessary.

Cold Therapy Wrap/Pad Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines TWC (Treatment in Workers Compensation), Shoulder Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the primary request for Vascutherm Cold Compression x 14 Day Rental is not medically necessary, the request associated with the service is also not supported.