

Case Number:	CM15-0003505		
Date Assigned:	01/14/2015	Date of Injury:	01/02/2008
Decision Date:	03/10/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	01/07/2015

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: New York, Pennsylvania, Washington
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

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 51 year old female was injured 1/2/08 with resulting injury to both shoulders. Current complaints are shooting left shoulder pain down trapezius and shoulder girdle causing numbness and tingling on the left, right shoulder pain and neck pain, which was deemed non-industrial. Medications are Norco, Flexaril, Tramadol and Nalfon. Diagnoses are impingement syndrome of the shoulders bilaterally, status post decompression and labral repair; sleep disturbances, stress and depression. Treatments include physical therapy and surgeries status post left shoulder arthroscopy, synovectomy, bursectomy, coracoacromial ligament release, acromioplasty and open procedure with biceps tendon release and stabilization and status post right shoulder surgery. She is currently using a Polar care Type unit for cooling and is requesting the heating aspect of that unit. On 12/5/14 Utilization review non-certified the request for VacuTherm device citing no specific medical justification for the device as only the third function of this device (heating) is requested. Utilization review recommends a heating pad or microwavable heat packs. ODG Low Back Chapter: Heat Therapy and Neck Chapter were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascu Therm: 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) Low Back Chapter, Heat Therapy; Knee Chapter; Neck Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints Page(s): 48 and 194-224.

Decision rationale: This injured worker has chronic shoulder pain with an injury sustained in 2008. The medical course has included numerous treatment modalities including surgery and use of several medications . The use of thermal modalities such as ice and/or heat can be used as modality to manage pain but given the chronicity of the pain and the use of numerous other medications, the medical necessity for vacutherm is not substantiated by the records. Also, it is not clear why the application of heat packs cannot be used instead of a vacutherm unit.