

Case Number:	CM15-0103528		
Date Assigned:	06/08/2015	Date of Injury:	04/20/2000
Decision Date:	07/13/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/29/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 60 year old female, who sustained an industrial injury on 4/20/2000. She reported pain of the bilateral shoulders, bilateral wrists, and bilateral knees. The injured worker was diagnosed as having left frozen shoulder, left shoulder tendinitis, left shoulder status post arthroscopy, right shoulder status post arthroscopy with rotator cuff repair, status post displaced fracture left humeral head greater tuberosity, right knee status post arthroscopy, right knee degenerative joint disease, left knee medial meniscus tear, and status post right carpal tunnel release with painful scar. Treatment to date has included medications, right knee surgery, right carpal tunnel release, right shoulder surgery, and imaging. The request is for vasculotherm ice therapy machine post-operatively, and continuous passive motion (CPM) unit post-operative. On 4/21/2015, she complained of left shoulder pain for which is awaiting left shoulder total replacement surgery. She is reported to be doing well from right carpal tunnel release, and indicated the numbness to be gone. Physical examination is revealed as unchanged. The treatment plan included: Diclofenac, Omeprazole, Ondansetron, and physical therapy, and vasculotherm ice therapy and CPM after surgery. The documentation does not indicate she is at risk for deep vein thrombosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Op Vascutherm Ice Therapy Machine: 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), Shoulder chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder chapter, continuous-flow cryotherapy.

Decision rationale: The patient presents with chronic bilateral shoulder pain. The current request is for Post-Op Vascutherm Ice Therapy Machine. Treatment to date has included medications, right knee surgery, right carpal tunnel release, right shoulder surgery, left shoulder surgery, physical therapy and imaging. The patient is not working. ODG guidelines under the shoulder chapter has the following regarding continuous-flow cryotherapy under shoulder: "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." The patient is status post left shoulder diagnostic arthroscopy on 02/18/15. This patient presents with complaints of continued left shoulder pain. Examination revealed significant range of motion limitation due to pain and weakness. The patient has a diagnosis of frozen left shoulder and the treater recommended a left shoulder replacement surgery, hospital stay, post op PT and post op Vascutherm and CPM unit. According to the Utilization review letter, the requested surgery has been authorized. In this case, the current request does not specify the duration of use and ODG guidelines support cryotherapy for post op use up to 7 days. The request is not medically necessary.

Post-Op Continuous Passive Motion (CPM) Unit: 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), Shoulder chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder chapter, passive motion devices (CPM).

Decision rationale: The patient presents with chronic bilateral shoulder pain. The current request is for Post-Op Continuous Passive Motion (CPM) Unit. Treatment to date has included medications, right knee surgery, right carpal tunnel release, right shoulder surgery, physical therapy and imaging. The patient is not working. ODG under its shoulder chapter has the following regarding passive motion devices (CPM), "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." ODG further states, "Rotator cuff tear: Not recommended after shoulder surgery or for non-surgical treatment." The patient is status post left shoulder diagnostic arthroscopy on 02/18/15. This patient presents with complaints of continued left shoulder pain. Examination revealed significant range of motion limitation due to pain and weakness. The patient has a diagnosis of frozen left shoulder and the treater recommended a left shoulder replacement

surgery, hospital stay, post op PT and post op Vascutherm and CPM unit. In this case, the medical reports document that this patient suffers from frozen shoulder and ODG supports the use of CPM units for the treatment of for adhesive capsulitis. However, the current request does not specify duration of use and ODG recommends CPM for up to weeks 5 days per week. This request is not medically necessary.