

Case Number:	CM15-0107115		
Date Assigned:	06/11/2015	Date of Injury:	03/25/2013
Decision Date:	08/18/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	06/03/2015

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, Pain Management

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 (IW) is a 52 year old female who sustained an industrial injury on 3/25/2013. She reported injury to the right shoulder. The injured worker was diagnosed as having rotator cuff syndrome. Treatment to date has included medication, physical therapy, and on 4/10/2015, a right shoulder diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa. Currently, the injured worker is postop right shoulder diagnostic operative arthroscopy with arthroscopic intra-articular debridement of the anterior labral tear, intra-articular glenohumeral synovectomy with arthroscopic subacromial decompression/acromioplasty, resection of the coracoacromial ligament with subacromial and subdeltoid bursectomy of the right shoulder, debridement of the bursal-sided rotator cuff fraying of the right shoulder, and an arthroscopic distal clavicle resection/Mumford procedure. A request for authorization is made for: Vascutherm cold compression rental for 14 days for the right shoulder, Compression therapy wrap purchase, Shoulder Continuous Passive Motion rental for 14 days and Sheepskin pad purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascutherm cold compression rental for 14 days for the 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, Treatment in Workers' Compensation, Shoulder Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Cold compression therapy.

Decision rationale: Regarding the request for Vascutherm cold compression, California MTUS and ACOEM do not contain criteria related to that request. ODG states that cold compression therapy is not recommended for the shoulder as there are no published studies. As such, the currently requested Vascutherm cold compression is not medically necessary.

Compression therapy wrap 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, Treatment in Workers' Compensation, Shoulder Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Shoulder Chapter, Cold compression therapy.

Decision rationale: Regarding the request for compression therapy wrap, it is intended for use with a cold compression device. The compression therapy device is not medically necessary. Therefore, the currently requested compression therapy wrap is not medically necessary.

Shoulder Continuous Passive Motion rental for 14 days: Upheld

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

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: Regarding the request for continuous passive motion machine, California MTUS and ACOEM do not contain criteria for this treatment modality. ODG states continuous passive motion is not recommended after shoulder surgery or for nonsurgical treatment. As such, the currently requested continuous passive motion machine 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, Treatment in Workers' Compensation, Shoulder Procedure Summary.

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: Regarding the request for sheepskin pad purchase, it appears that this is for use with the continuous passive motion device. The CPM device is not medically necessary. As such, the currently requested sheepskin pad purchase is not medically necessary.