

Case Number:	CM15-0022291		
Date Assigned:	02/11/2015	Date of Injury:	11/01/2010
Decision Date:	04/21/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/05/2015

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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 58 year old male, who sustained an industrial injury on November 1, 2010. He has reported bilateral shoulder pain. Diagnoses have included right shoulder labral tear and SLAP tear. Treatment to date has included physical therapy, left shoulder surgery, and imaging studies. A progress note dated October 16, 2014 indicates a chief complaint of right shoulder pain and crepitus. The treating physician documented a plan of care that included future right shoulder surgery after recovery from left shoulder surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

V-Pulse Machine rental for 21 days, 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) Shoulder, Venous thrombosis, Continuous passive motion (CPM), Compression garments.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Cold Therapy Units, Other Medical Treatment Guideline or Medical Evidence:

<http://www.deroyal.com/medicalproducts/orthopedics/product.aspx?id=pc-temptherapy-coldtherunit>.

Decision rationale: A V-Pulse Machine is a cold therapy unit. "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007)" The use of devices that continually circulate a cooled solution via a refrigeration machine have not been shown to provide a significant benefit over ice packs. As such the request for V-Pulse Machine rental for 21 days, Right Shoulder is not medically necessary.

Continuous Passive Motion Rental for 21 days, 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) Shoulder, Venous thrombosis, Continuous passive motion (CPM), Compression garments.

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: MTUS is silent with regards to a Continuous Passive Motion (CPM) unit. ODG states, "Recommended as indicated below, for in-hospital use, or for home use in patients at risk of a stiff knee, based on demonstrated compliance and measured improvements, but the beneficial effects over regular PT may be small. Routine home use of CPM has minimal benefit." ODG further quantifies, Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures: (1) Total knee arthroplasty (revision and primary); (2) Anterior cruciate ligament reconstruction (if inpatient care); (3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint. (BlueCross BlueShield, 2005) For home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight: (1) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with: (a) complex regional pain syndrome; (b) extensive arthrofibrosis or tendon fibrosis; or (c) physical, mental, or behavioral inability to participate in active physical therapy. (2) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies. Medical records indicate that the patient is in excess of the acute hospital setting. The request is in excess 17 day at home setting. The treatment notes do not specify extenuating circumstances why regular physical therapy cannot be initiated or why an exception to guidelines should be granted. As such, the request for

Continuous Passive Motion Rental for 21 days, Right Shoulder is not medically necessary at this time.

Continuous Passive Motion Pad purchase, 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) Shoulder, Venous thrombosis, Continuous passive motion (CPM), Compression garments.

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: MTUS is silent with regards to a Continuous Passive Motion (CPM) unit. ODG states, "Recommended as indicated below, for in-hospital use, or for home use in patients at risk of a stiff knee, based on demonstrated compliance and measured improvements, but the beneficial effects over regular PT may be small. Routine home use of CPM has minimal benefit." ODG further quantifies, Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures: (1) Total knee arthroplasty (revision and primary); (2) Anterior cruciate ligament reconstruction (if inpatient care); (3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint. (BlueCross BlueShield, 2005) For home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight: (1) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with: (a) complex regional pain syndrome; (b) extensive arthrofibrosis or tendon fibrosis; or (c) physical, mental, or behavioral inability to participate in active physical therapy. (2) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies. Medical records indicate that the patient is in excess of the acute hospital setting. The request is in excess 17 day at home setting. The treatment notes do not specify extenuating circumstances why regular physical therapy cannot be initiated or why an exception to guidelines should be granted. As such, the request for Continuous Passive Motion Pad purchase, Right Shoulder is not medically necessary at this time.