

Case Number:	CM15-0011222		
Date Assigned:	01/28/2015	Date of Injury:	10/19/2012
Decision Date:	03/30/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/20/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, 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 is a 57 year old male, who sustained an industrial injury on 10/19/2012. The diagnoses have included end stage glenohumeral arthritis of the right shoulder and end stage osteoarthritis of the right shoulder. Magnetic resonance imaging (MRI) dated 10/17/2013 revealed grade 4 chondromalacia of the glenohumeral joint with severe cartilage loss. On 11/21/2014 he underwent a right shoulder diagnostic arthroscopy, arthroscopic subacromial decompression and acromioplasty, arthroscopic resection of coracoacromial ligament, arthroscopic extensive subacromial and sub deltoid bursectomy, glenohumeral debridement, distal clavicle resection and Mumford procedure, debridement of labrum and labral fraying and debridement of partial rotator cuff repair. Currently, the IW complains of right shoulder and arm pain. Objective findings included pain with cross arm horizontal abduction of the right shoulder forward flexion and abduction of 155 degrees. On 12/23/2014, Utilization Review non-certified a request for shoulder CPM 14 day rental and sheepskin pad purchase and modified a request for vascutherm cold compression 14 day rental and compression therapy pad purchase noting that the clinical findings do not support the medical necessity of the treatment. MTUS, Non-MTUS, ACOEM and ODG were cited. On 1/20/2015, the injured worker submitted an application for IMR for review of vascutherm cold compression 14 day rental, compression therapy pad purchase, shoulder CPM 14 day rental 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 (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-Treatment in Workers' Compensation (ODG-TWC) Shoulder Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, Continuous-Flow Cryotherapy

Decision rationale: Per internet search, Vascutherm is a device which combines compression, localized thermal therapy, contrast therapy, and DVT prophylaxis. The MTUS is silent on the use of cold therapy units. Per the ODG guidelines: "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. The guidelines only support the use of cryotherapy devices for 7 days postoperatively. As the request is for 14 day rental, medical necessity cannot be affirmed.

Compression Therapy Pad (Purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Continuous Passive Motion (CPM) 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-Treatment in Workers' Compensation (ODG-TWC) Shoulder Procedure Summary Blue Cross of California Medical Policy #DME.00019: CPM Devices

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, Continuous Passive Motion (CPM)

Decision rationale: The MTUS is silent on the use of shoulder CPM rentals. Per ODG TWC with regard to shoulder CPM: "Not recommended after shoulder surgery or for nonsurgical treatment. (Raab, 1996) (BlueCross BlueShield, 2005) An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various

operative and nonoperative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength."As the request is not recommended by the guidelines, it 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 (ODG-TWC) Shoulder Procedure Summary

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.