

Case Number:	CM15-0171996		
Date Assigned:	09/14/2015	Date of Injury:	06/09/2014
Decision Date:	10/15/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	09/01/2015

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 42 year old female who sustained an industrial injury on 06-09-2014. Current diagnoses include chronic left shoulder external impingement, bursitis, and superior labral tear. Report dated 05-18-2015 noted that the injured worker presented with complaints that included left shoulder pain. Pain level was 7 out of 10 on a visual analog scale (VAS). Physical examination on 05-18-2015 revealed decreased left shoulder range of motion, guarding with range of motion testing, decreased muscle strength on the left, tenderness in the acromioclavicular joint on the left, tenderness in the left rotator cuff, positive Jobe test, Neer impingement sign, Hawkin's impingement sign, and lift off test, tenderness in the bicipital groove and positive O'Brien's test. Previous treatments included medications, injection, and physical therapy. The treatment plan included request for surgery. Shoulder surgery was performed on 07-31-2015. Request for authorization dated 07-31-2015, included requests for cold compression therapy 14 day rental, compression pad purchase, SCPM 21 day rental, and CPM pad purchase. The utilization review dated 08-14-2015, non-certified the request for rental-purchase of cold compression therapy x 14 days, compression pad purchase, CPM x 21 day rental, and CMP pad purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold compression therapy x 14 day rental and compression pad purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Ankle and Foot Complaints 2004.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, Cold compression therapy, it is not recommended in the shoulder, as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. As the guidelines do not recommend the requested DME, the determination is for non-certification. The request is not medically necessary.

CPM (continuous passive motion) x 21 day rental and CPM 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 (ODG), Knee Chapter, page 2010.

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, Continuous passive motion (CPM).

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis in the cited records, the determination is for non-certification. The request is not medically necessary.