

Case Number:	CM13-0027023		
Date Assigned:	01/31/2014	Date of Injury:	12/03/2007
Decision Date:	04/28/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/20/2013

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 62 female patient with 8/07 and 1/08 dates of injury. This patient underwent a left shoulder diagnostic and operative arthroscopy on 6/19/09. She continues to make slow progress with her shoulder. She has stiffness, achiness and discomfort with weakness of the right shoulder. She has difficulty sleeping at night due to pain and difficulty with activities of daily living. She had a previous right shoulder MRI 10/19/09 which demonstrated partial tearing and bursal surface of the rotator cuff with partial fraying of the subscapularis and down sloping of the acromion with significant impingement. Examination revealed right shoulder tenderness of the subacromial bursal space and shoulder girdle musculature with positive provocative testing, forward flexion and abduction to 135. Left shoulder forward flexion and abduction to 160 degrees. She has been treated with activity modification, medication, and exercises. A course of therapy was recommended 2/28/13. A 9/4/13 utilization review rendered an adverse determination because a diagnosis of adhesive capsulitis was not established.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 WEEK RENTAL OF A CONTINUOUS PASSIVE MOTION (CPM) MACHINE FOR RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG TWC 2013 Shoulder, (CPM).

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.

Decision rationale: CA MTUS does not address CPM for the shoulder. ODG states that continuous passive motion is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. However, the course of alternative conservative care, including duration and response to therapy, is not clear from the records. While ROM (Range Of Movement) was noted to be restricted, it is unclear from the recent physical exam whether those restrictions were with active or passive ROM (Range of Movement). The patient has not undergone recent surgery. Therefore, the request for four (4) weeks rental of a Continuous Passive Motion (CPM) machine for right shoulder is not medically necessary and appropriate.

PURCHASE OF PAD FOR RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.