

Case Number:	CM13-0051731		
Date Assigned:	12/27/2013	Date of Injury:	02/15/2012
Decision Date:	08/12/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	11/14/2013

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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:

The injured worker is a 58 year old female who has a date of injury of 02/15/12. The mechanism of injury is not adequately described; however, the records suggest that the injured worker developed cervical and bilateral shoulder pain as a result of cumulative trauma. The record indicates that the injured worker has undergone extensive treatment for her cervical complaints which has included facet injections and cervical epidural steroid injections. The record contains an electrodiagnostic study (EMG/NCV) dated 08/07/13 which indicates mild bilateral carpal tunnel syndrome and a left ulnar neuropathy at the wrist. The injured worker was ultimately deemed to have failed conservative management which included prescription medications and intraarticular injections. The record contains multiple urine drug screens which indicate that the injured worker did not appear to take her medications as prescribed. The record contains a clinical note dated 10/01/13 in which the injured worker complains of left shoulder pain. On physical examination, there was tenderness over the acromioclavicular joint. Range of motion of the left upper extremity was grossly intact. There was tenderness in the periscapular region as well as in the supraspinatus fossa. Left shoulder range of motion was noted to be 100 degrees in abduction, forward flexion to 100 degrees, extension to 30 degrees, and adduction to 30 degrees. External and internal rotation is 40 degrees bilaterally. Impingement sign, Hawkins' sign, and supraspinatus weakness tests were positive. Left shoulder is graded as 4-/5 globally. The record indicates a request for authorization for a left shoulder arthroscopy, open versus arthroscopic rotator cuff repair, subacromial decompression, and distal clavicle resection. The record contains a utilization review determination dated 10/17/13 in which requests for a continuous passive motion machine for the left shoulder and cold therapy unit were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUOUS PASSIVE MOTION (CPM) FOR LEFT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-SHOULDER (UPDATED 06/12/13), CONTINUOUS PASSIVE MOTION (CPM).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER CHAPTER, CONTINUOUS PASSIVE MOTION.

Decision rationale: Per both the ACOEM Guidelines and the Official Disability Guidelines, the use of continuous passive motion (CPM) on a postoperative shoulder is not recommended due to the lack of peer reviewed literature establishing the efficacy of this postoperative therapeutic treatment. As such, the request is not medically necessary and appropriate.

COLD THERAPY UNIT LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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.

Decision rationale: Per the Official Disability Guidelines, cold therapy is not recommended in the shoulder, as there are no published studies. It may be an option for other body parts. As such, medical necessity is not established and the request is not medically necessary and appropriate.