

Case Number:	CM13-0065429		
Date Assigned:	01/03/2014	Date of Injury:	03/19/2010
Decision Date:	07/30/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/13/2013

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 Orthopedic 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 64-year-old male who reported an injury on 03/19/2010 with the mechanism of injury not cited within the documentation provided. In the clinical notes dated 05/13/2014, the injured worker was being seen for a follow-up of the left shoulder. Prior treatments included left shoulder arthroscopy/rotator cuff repair dated 10/12/2012, physical therapy, and prescribed medications. The injured worker's prescribed medications included ibuprofen 600 mg 1 tablet 3 times a day. The physical examination of the left shoulder revealed crepitus on range of motion. It was noted that there was a positive impingement sign with forward flexion, resisted abduction, adduction, and internal rotation. It was also noted that there were negative apprehension test, sulcus sign, O'Brien's test, and negative cross arm abduction test. The supraspinatus strength was noted at 4/5 and external rotation strength was noted at 4/5. There was also a negative subscapular lift off test. The diagnosis included unspecified disorders of bursa and tendons in shoulder region. The treatment plan included physical therapy with strengthening exercises and work restrictions of no lifting greater than 10 pounds with minimal overhead use. The request for authorization for DME CPM unit rental or rationale was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME CPM UNIT RENTAL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

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: The request for DME CPM unit rental is not medically necessary. The Official Disability Guidelines state that continuous passive motion (CPM) is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. In the clinical notes provided for review, there is not enough documentation of the request being made for the continuous passive motion unit. There is also not enough documentation of the injured worker's pain level status and efficacy of the prescribed pain medications. It is also documented that the injured worker is status post left shoulder arthroscopy/rotator cuff repair 10/12/2012. Furthermore, the guidelines do not recommend CPM after shoulder surgery or for nonsurgical treatment. Therefore, the request for a DME CPM unit rental is not medically necessary.