

Case Number:	CM14-0000504		
Date Assigned:	01/10/2014	Date of Injury:	02/19/2013
Decision Date:	06/11/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	01/02/2014

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, has a subspecialty in Internal 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:

According to the records made available for review, this is a 75-year-old with a February 19, 2013 date of injury. At the time of request for authorization for cold therapy unit (CTU) rental for fourteen days, and continuous passive motion unit (CPM) rental fourteen days (October 9, 2013), there is documentation of subjective (right shoulder pain) and objective (tenderness over the front and back of the shoulder, limited range of motion, painful arc of motion of 90 degrees, positive Supraspinatus test, and positive impingement sign) findings, imaging findings (MRI Right Shoulder (June 24, 2013) report revealed large distal full thickness supraspinatus rotator cuff tear with retraction to the cervical level), current diagnosis (complete rupture of rotator cuff), and treatment to date (physical therapy, activity modification, and medications). Medical report identifies that outpatient right shoulder scope rotator cuff tendon repair with distal clavicle resection and acromioplasty has been authorized/certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT (CTU) RENTAL FOR FOURTEEN DAYS (14): Upheld

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

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-Flow Cryotherapy.

Decision rationale: MTUS does not address this issue. ODG identifies continuous-flow cryotherapy is recommended as an option after surgery for up to seven days, including home use. Within the medical information available for review, there is documentation of a diagnosis of complete rupture of rotator cuff. In addition, there is documentation of a pending surgery that is authorized/certified. However, the requested cold therapy unit (CTU) rental for fourteen days exceeds guidelines (up to seven days, including home use). The request for a CTU rental for fourteen days is not medically necessary or appropriate.

CONTINUOUS PASSIVE MOTION UNIT (CPM) RENTAL FOURTEEN DAYS (14):
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) Shoulder Chapter, Continuous Passive Motion (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 (CPM).

Decision rationale: MTUS does not address the issue. ODG identifies documentation of adhesive capsulitis up to five days weekly for four weeks, as criteria necessary to support the medical necessity of continuous passive motion. ODG also notes that continuous passive motion is not recommended for shoulder rotator cuff problems, after shoulder surgery, or for nonsurgical treatment. Within the medical information available for review, there is documentation of a diagnosis of complete rupture of rotator cuff. In addition, there is documentation of a pending surgery that is authorized/certified. However, there is no documentation of adhesive capsulitis. The request for a CPM rental or fourteen days is not medically necessary or appropriate.