

Case Number:	CM14-0000896		
Date Assigned:	01/22/2014	Date of Injury:	04/01/2012
Decision Date:	03/25/2014	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 a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation, 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 physician 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 patient is 46 year old female with stated date of injury of 4/01/12, S/P Right shoulder arthroscopy with subacromial decompression, injection of Methylene Blue and open rotator cuff repair who is complaining of increased pain in the right shoulder after she jerked her arm in her sleep. Upon physical exam wound healed, passive motion 10 degrees, no pain with abduction. An open right rotator cuff repair and arthroscopy with subacromial decompression were performed on 10/22/13. At follow-up on 11/14/13, the patient reported increased right shoulder pain after she jerked her arm in her sleep 2-3 days earlier. She was wearing a shoulder-immobilizer. Limited physical exam findings included "wound healed-passive motion-10 [degrees]" and "FF/abd-no pain." At issue is the request for Continuous passive motion (CPM) device post rotator cuff surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder CPM unit, rental x 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) online.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC--Shoulder (Acute & Chronic) (updated 01/20/14) Continuous passive motion (CPM).

Decision rationale: With respect for the request for Shoulder CPM unit, rental x 30 days, the ODG guideline does not recommend this device for shoulder rotator cuff problems, but is recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. "RV 1 week to begin PT" was the treatment plan, in the handwritten progress note dated 11/14/2013. Therefore the request for Shoulder CPM unit, rental x 30 days is not medically necessary.