

<b>Case Number:</b>	CM14-0024382		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	09/10/2011
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2014

### 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 Orthopedic Surgery 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:

The injured worker is a 54-year-old female who reported an injury on 09/20/2011. The mechanism of injury was from preventing a fall. Within the clinical note dated 02/10/2014, it was reported the injured worker complained of shoulder pain involving the left shoulder. The injured worker has been treated with narcotics and Vicodin. She is status post decompression and has a frozen shoulder. The injured worker underwent a steroid injection which has not helped. The injured worker reported the left shoulder was in constant pain. She described the pain as catching, burning, aching, and acute and associated with stiffness, limited range of motion, and weakness. She rated her pain 8/10 in severity. The injured worker reported having difficulty with activities of daily living. Within the physical examination, the provider noted left shoulder range of motion flexion at 80 degrees. The provider indicated there was tenderness to palpation over the left shoulder. The left shoulder forward flexion strength was 5/5 with normal muscle tone. External rotation strength was 5/5 and internal rotation strength was 5/5. The provider recommended the injured worker to undergo an arthroscopic capsular release. Prior treatments included decompression of the shoulder, steroid injections, and pain medication. The provider requested for a game-ready ice machine for 7 to 10 days, and a continuous passive motion for 3 weeks following surgery. The Request for Authorization was provided and submitted on 02/12/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**GAME READY ICE MACHINE FOR 7 - 10 DAYS:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Game Readyâ€¢ accelerated recovery system, Continuous-flow cryotherapy.

**Decision rationale:** The injured worker complained of shoulder pain involving the left shoulder. She described the pain as catching, burning, aching, and acute, and associated with stiffness, limited range of motion, and arm movements. She rated her pain 8/10 in severity. She reported difficulty with her activities of daily living. The Official Disability Guidelines recommend a game ready accelerated recovery system as an option after surgery, but not for nonsurgical treatments. The game ready system combines continuous flow cryotherapy with the use of laser compression. The ODG recommend continuous flow cryotherapy after surgery, but not for nonsurgical treatments. Postoperative use generally may be up to 7 days including home use. There is a lack of clinical documentation submitted indicating whether the injured worker has undergone surgical intervention. Additionally, the request submitted exceeds the ODG recommendations for use for 7 days including home use. As such, the request is not medically necessary and appropriate.

**CONTINUOUS PASSIVE MOTION (CPM) FOR 3 WEEKS:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Continuous passive motion.

**Decision rationale:** The Official Disability Guidelines recommend continuous passive motion for in-hospital use or home use in patients with risk of stiff knee, based on demonstrated compliance, and measured improvements, but the beneficial effects of regular physical therapy may be small. The ODG recommend continuous passive motion for up to 17 days after surgery with patients with a stiff knee or are unable to bear weight. The request submitted for 3 weeks of continuous passive motion exceeds the guideline recommendations of 17 days. Therefore, the request is not medically necessary and appropriate.