

<b>Case Number:</b>	CM14-0063002		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	05/20/2011
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	03/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2014

### 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 injury to the right shoulder on 05/20/2011 secondary to a slip and fall. The injured worker complained of severe right shoulder and cervical pain. According to note dated 02/21/2014 the injured worker had impingement signs in the right shoulder, significant deficits with range of motion with a painful arc and tenderness over the capsule that required manipulation under anesthesia. A note dated 02/04/2014 stated that the injured worker could only actively abduct to 90 degrees. She is status post arthroscopic surgery of right shoulder on 09/13/2013. There were no recent diagnostics submitted pertaining to the request. Per note dated 02/21/2014 an electromyogram and nerve conduction study was done on 3/12/2013 that showed evidence of a moderate right carpal tunnel syndrome, with prolonged median motor latency across the wrist, slowing of the right median sensory nerve conduction velocity, and small median amplitude. There was no evidence of ulnar and radial neuropathy or significant cervical radiculopathy. The injured worker had diagnoses of pain in shoulder joint, unspecified major depression, recurrent episode, pain in joint, lower leg, lumbar and cervical disc displacement without myelopathy. She had past treatments of medications, cortisone injections, physical therapy, heat and ice, home exercise program, acupuncture and transcutaneous electrical nerve stimulation. Her medications were Cyclobenzaprine 7.5mg one to two tabs daily as needed, Gabapentin 600mg one tab twice a day, Buprenorphine 0.25mg sublingual troches one twice a day as needed, and Ketamine 5% cream three time a day. The treatment plan is for continuous passive motion machine and for unknown sessions of post-operative physical therapy for the right shoulder. The request for authorization form was not submitted for review. There is no rationale for the requests for continuous passive motion machine and for unknown sessions of post-operative physical therapy for the right shoulder.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Continuous Passive Motion Machine:** 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), Treatment Index, 11th edition (web), 2013, Shoulder (Acute and Chronic).

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

**Decision rationale:** The Official Disability Guidelines (ODG) for shoulder complaints, continuous passive motion (CPM) does not recommend CPM for rotator cuff problems, but does recommend it as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The request does not specify the reason for CPM. Therefore the request for continuous passive motion machine is not medically necessary and appropriate.

### **Unknown sessions of Post- operative physical therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 26.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

**Decision rationale:** The MTUS Post-Surgical Treatment Guidelines for impingement syndrome and adhesive capsulitis recommend postsurgical treatment of 24 visits over 14 weeks. In this case, the request does not specify the number of sessions requested. Therefore the request for unknown sessions of post-operative physical therapy for the right shoulder is not medically necessary and appropriate.