

<b>Case Number:</b>	CM13-0034911		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	09/10/2012
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	10/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 61-year-old female who reported an injury on 09/10/2012. The mechanism of injury involved repetitive activity. The current diagnoses include tendinitis of the forearm, impingement syndrome of the shoulder, De Quervain's tenosynovitis, medial epicondylitis, lateral epicondylitis, and wrist joint pain. The injured worker has been previously treated with physical therapy, medication management, bracing, and a shoulder injection. The latest physician's progress report submitted for this review was documented on 07/12/2013. The injured worker presented with complaints of persistent pain rated 8/10 with radiation up into the elbow and biceps area. The injured worker was working under light duty restrictions. The injured worker also reported an aggravation of pain with activity and exercise therapy. Upon examination of the left shoulder, there was 138 degrees flexion, 40 degrees extension, 132 degrees abduction with severe pain, 30 degrees adduction, 92 degrees external rotation, and 62 degrees internal rotation. There were positive Neer's and Hawkins signs and intact sensation with 5/5 motor strength. Recommendations at that time included continuation of the current medication regimen. The injured worker was then referred for an MRI of the bilateral shoulders. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continuous passive motion machine 4 weeks rental:** 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, 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 flow cryotherapy.

**Decision rationale:** The Official Disability Guidelines recommend continuous flow cryotherapy following surgery for up to 7 days. There was no indication that this injured worker has previously undergone a surgical procedure for the right shoulder. The medical necessity has not been established. Additionally, the request for a cold therapy unit for 4 weeks would exceed guideline recommendations. As such, the request is not medically appropriate.

**Cold therapy unit 4 weeks rental for right shoulder:** 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) Shoulder Chapter, Continuous passive motion.

**Decision rationale:** The Official Disability Guidelines state continuous passive motion is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The injured worker does not maintain a diagnosis of adhesive capsulitis. The current request for a 4 week rental would fall within guideline recommendations. However, the injured worker does not meet criteria for the requested durable medical equipment. As such, the request is not medically appropriate at this time.