

Case Number:	CM14-0000557		
Date Assigned:	06/11/2014	Date of Injury:	11/09/2009
Decision Date:	01/31/2015	UR Denial Date:	12/24/2013
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 Orthopedic Surgery and is licensed to practice in Minnesota. 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:

This is a 47 year old female who sustained a work injury to her lower back, left wrist, left thumb and left shoulder as a result of a continuous trauma injury from 11/09/2008 to 11/09/2009. Prior treatment consisted of the following: -Initial treatment with pain medications-Referral to an orthopedist-X-rays, MRI, EMG and nerve conduction studies -Off work-Home exercises-DeQuervains release 02/23/2009 with "good results"-Referral to a Neurologist-Physical therapy-Pain managementX-ray, MRI reports, EMG, nerve conduction studies, specialty consults and surgical report is not available in the submitted records. The number of physical therapy visits, results or physical therapy records is not submitted for review. Injections and anti-inflammatory medications are mentioned however the nature or results of the injections are not documented. The only record submitted is 11/26/2013 when she presented for a consultation of the left shoulder. The injured worker (IW) was complaining of left shoulder pain with radiation into her left arm down to her wrist. She described the pain as continuous, sharp in nature and had been increasing over the past several months. She also had numbness and tingling in her left hand. . On a scale of 1-10 she rated pain as 8-10. MRI (not in submitted records) done on 06/13/2011 indicated mild rotator cuff tendinosis with thickening of a subacromial bursa; intact biceps labral complex and an inferior glenohumeral ligament labral complex; subscapularis tendinosis with tendon thickening; and synovitis rotator cuff interval.Prior history included bilateral wrist surgery with the only one occurring after her work injury being DeQuervains release 02/23/2009. Medical history included fibromyalgia. The provider documented the left shoulder condition had not resolved with long standing conservative management including injections, physical therapy and anti-inflammatory medications. Physical exam of the left shoulder revealed a decrease in motor strength in the left upper extremity. The left shoulder was tender with decreased range of motion. The provider requested arthroscopic acromioplasty (left shoulder)

and distal clavicle resection which was approved. The provider requested authorization for post-surgical continuous passive motion machine (CPM) to help aid in mobility following surgery. Continuous cold therapy was requested for 4 weeks. On December 24, 2013 utilization review issued a decision regarding CPM stating it was not recommended for the shoulder. The request for continuous cold therapy was approved for 7 days stating post-operative use generally may be up to 7 days including home use. Guidelines cited were Official Disability Guidelines - Continuous Flow Cryotherapy and Continuous Passive Motion (CPM). The decision was appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuous passive motion (CPM) 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), 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) Section: Shoulder, topic: Continuous Passive Motion

Decision rationale: California MTUS guidelines do not address this issue. ODG guidelines are therefore used. The guidelines do not recommend continuous passive motion for arthroscopy of the shoulder with subacromial decompression or for rotator cuff surgery. The only indication is adhesive capsulitis. The documentation indicates presence of impingement syndrome but range of motion of the shoulder was good preoperatively and there was no evidence of adhesive capsulitis. As such, the request for continuous passive motion device rental after surgery is not recommended and the medical necessity of the request is not substantiated.

Continuous cold therapy times four (4) weeks: 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), Continuous Flow Cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: Continuous Flow Cryotherapy

Decision rationale: California MTUS guidelines do not address this issue. ODG guidelines are therefore used. Continuous flow cryotherapy is recommended as an option after shoulder surgery for 7 days. Use beyond 7 days is not recommended. It reduces swelling, inflammation, pain, and reduces the need for narcotics postoperatively. As such, the request for continuous flow cryotherapy for 4 weeks is not supported by guidelines and the medical necessity is not established.

