

<b>Case Number:</b>	CM14-0197596		
<b>Date Assigned:</b>	12/05/2014	<b>Date of Injury:</b>	04/20/2013
<b>Decision Date:</b>	01/26/2015	<b>UR Denial Date:</b>	10/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Physical Medicine Rehab, has a subspecialty in Interventional spine 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 patient is a 48 year old female with an injury date of 04/20/13. Based on the 09/22/14 progress report provided by treating physician, the patient complains of right shoulder pain that affects her sleep and activities of daily living. Physical examination to the right shoulder revealed no surgical incisions. Tenderness and spasm to the right deltoid. Range of motion was decreased, especially on flexion 140 degrees and abduction 120 degrees. Positive Empty Can and Impingement tests. Patient states that cortisone injections in the past have failed. Patient is taking Ibuprofen and attending acupuncture treatment. Per progress report dated 09/22/14, treater is planning Right Shoulder Arthroscopy "as the patient has positive MRI findings and has failed conservative measures including cortisone injections, physical therapy and medication." Treater is requesting CPM unit to retain range of motion post-operatively. Medications include Tramadol, Relafen and Omeprazole per treater report dated 06/30/14 and 08/11/14. The patient is temporarily totally disabled. Diagnosis 05/20/14; narrowing of AC outlet, moderate subacromial/subdeltoid bursitis, and small full thickness tear of distal anterior fibers of supraspinatus tendon and mild glenohumeral joint effusion, per MRI , right shoulder, 04/02/14. Diagnosis 09/22/14; cervical disc syndrome; right shoulder rotator cuff syndrome; lumbar facet syndrome; right shoulder impingement; right medial epicondylitis; right carpal tunnel syndrome The utilization review determination being challenged is dated 10/29/14. Treatment reports were provided from 04/22/14 - 09/22/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CPM Unit for 30 days:** 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), Shoulder (Acute & Chronic) chapter, Continuous passive motion (CPM).

**Decision rationale:** The patient presents with right shoulder pain that affects her sleep and activities of daily living. The request is for CPM unit for 30 days. Patient's diagnosis on 09/22/14 included right shoulder rotator cuff syndrome, right shoulder impingement, lumbar facet syndrome, right medial epicondylitis, and right carpal tunnel syndrome. Physical examination to the right shoulder revealed no surgical incisions. Tenderness and spasm to the right deltoid. Range of motion was decreased, especially on flexion 140 degrees and abduction 120 degrees. Positive Empty Can and Impingement tests. Patient states that cortisone injections in the past have failed. Patient is taking Ibuprofen and attending acupuncture treatment. Medications include Tramadol, Relafen and Omeprazole per treater report dated 06/30/14 and 08/11/14. The patient is temporarily totally disabled. The ACOEM and MTUS do not discuss Continuous passive motion devices. ODG Shoulder Chapter has the following regarding continuous passive motion devices (CPM), "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." ODG further states, "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." Per progress report dated 09/22/14, treater is planning Right Shoulder Arthroscopy "as the patient has positive MRI findings and has failed conservative measures including cortisone injections, physical therapy and medication." Treater is requesting CPM unit to retain range of motion post-operatively, however there is no indication that surgery has been authorized. Furthermore, review of medical records do not show documentation of adhesive capsulitis, for which CPM devices are indicated. The patient does not meet ODG criteria for the use of a CPM device. Therefore the request is not medically necessary.