

Case Number:	CM15-0182698		
Date Assigned:	09/23/2015	Date of Injury:	08/10/2014
Decision Date:	10/28/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/17/2015

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 59 year old female, who sustained an industrial injury on 8-10-14. The injured worker was diagnosed as having disorders of bursae and tendons shoulder region; osteoarthritis unspecified shoulder; pain in joint shoulder. Treatment to date has included physical therapy; right shoulder joint injections; medications. Diagnostics studies included MRI right shoulder (10-21-14). Currently, the PR-2 notes dated 4-20-15 indicated the injured worker complains of continued right shoulder pain when he moved his right shoulder. He reports he feels a pinch pain and the pain limits his work and wakes him from sleep at night. He has been taking Relafen. Objective findings as documented as "right shoulder flexion and abduction at 10, internal rotation decreased to 50, limited adduction, marked painful crepitus, positive cross arm AC compression, equivocal biceps-labral signs, weakness of abduction." The provider notes his treatment plan included right shoulder arthroscopy due to failed 8 months of treatment with NSAIDs, steroid injection producing only one month of relief with pain returning. He notes the examination and MRI of the right shoulder are consistent. His MRI of the right shoulder documents "Moderately severe degenerative arthritis right acromioclavicular joint. There is tendinosis of supraspinatus and subscapularis tendons, biceps tendinitis with increased fluid around the biceps tendon, degenerative arthritis glenohumeral joint." Surgery y was scheduled for right shoulder arthroscopy rotator cuff repair, subacromial decompression acromioclavicular joint resection, possible tenotomy tenodesis (8-7-15). A Request for Authorization is dated 9-17-15. A Utilization Review letter is dated 8-20-15 and non-certification was for a Right shoulder continuous passive motion 2 weeks' rental and Soft Good Pad for purchase. Utilization Review denied the requested treatment for not meeting the ODG Guidelines. A request for

authorization has been received for a Right shoulder continuous passive motion 2 weeks rental and Soft Good Pad for purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder continuous passive motion 2 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 (updated 08/06/2015) Online version.

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: CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis in the cited records, the determination is not medically necessary.

Soft Good Pad for purchase: 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 (updated 07/30/2015), online version.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: According to the California MTUS guidelines, Shoulder complaints Chapter 9 pages 212-214, it is recommended to use a brief use of the sling for severe shoulder pain (1-2 days) with pendulum exercises to prevent stiffness and cases of rotator cuff conditions, and prolonged use of the sling only for symptom control is not supported. In this case the use of a shoulder sling would be contraindicated following right shoulder arthroscopy to prevent adhesive capsulitis. The request for a sling is therefore not medically necessary or appropriate.