

<b>Case Number:</b>	CM15-0182925		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	02/22/2013
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	08/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 61 year old male with an industrial injury date of 02-22-2013. Medical record review indicates he is being treated for status post right shoulder arthroscopy with rotator cuff repair, left shoulder glenohumeral arthrosis with chronic massive retracted rotator cuff tear and cuff tear arthropathy and status post bilateral total knee arthroplasty. Subjective complaints (08-04-2015) included left shoulder pain. The pain rating is documented as 7 out of 10. The injured worker states his left shoulder is "responsible for 80%" of his pain. Physical exam noted abduction and forward flexion were limited to 70 degrees by pain. Other documented findings of physical exam included severe weakness with internal and external rotation and severe pain in the subacromial space of the left shoulder and along the glenohumeral joint anteriorly. Work status on 08-04-2015 is documented as "temporarily totally disabled. Prior treatments "tried and failed" included physical therapy, "several different anti-inflammatory medications," "multiple cortisone injections to the left shoulder" and pain medication. The treating physician recommended the injured worker "proceed with a reverse left total shoulder arthroplasty." The treatment request for review included: (Associated Services) DME: shoulder CPM (continuous passive motion) unit; (Associated Services) Cold therapy unit purchase. On 08- 24-2014 the request for: (Associated Services) DME: shoulder CPM (continuous passive motion) unit was denied by utilization review. (Associated Services) Cold therapy unit purchase was modified to a 7 day rental by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(Associated Services) DME: shoulder CPM (continuous passive motion) unit: 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 Chapter.

**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 for non-certification. Therefore, the requested treatment is not medically necessary.

**(Associated Services) Cold therapy unit 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 Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold compression therapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, Cold compression therapy, it is not recommended in the shoulder as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. As the guidelines do not recommend the requested DME, the determination is for non-certification. Therefore, the requested treatment is not medically necessary.