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| Case Number: | CM15-0191444 | | |
| Date Assigned: | 10/05/2015 | Date of Injury: | 02/12/2015 |
| Decision Date: | 11/10/2015 | UR Denial Date: | 09/11/2015 |
| Priority: | Standard | Application Received: | 09/29/2015 |

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 62 year old male who sustained an industrial injury on 02-12-2015. According to an initial comprehensive orthopaedic consultation report dated 08-19-2015, the injured worker reported "moderate" left shoulder pain aggravated with any attempted lifting, reaching and pushing activities. Neer impingement test, Hawkins impingement test and Jobe test was positive on the left. Acromioclavicular (AC) joint tenderness was present on the left. Anterior and posterior AC joint stress test was positive on the left. Motor strength was decreased in the left with external and internal rotation. MRI of the left shoulder demonstrated a complete rotator cuff tear, fluid in the subacromial bursa, type II acromion and degenerative spurring at the acromioclavicular joint. Diagnoses included symptomatic traumatic rotator cuff tear, impingement syndrome and distal clavicle arthrosis left shoulder. The provider recommended arthroscopic rotator cuff repair, acromioplasty and distal clavicle resection. An authorization request dated 09-08-2015 was submitted for review. The requested services included left shoulder arthroscopic rotator cuff repair acromioplasty distal clavicle resection, postoperative physical therapy, cold therapy unit, Ultrasling and shoulder continuous passive motion. On 09-11-2015, Utilization Review non-certified the request for continuous passive motion left shoulder and authorized the request for cold therapy unit and Ultrasling left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuous Passive Motion, left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 section, Continuous passive motion.

Decision rationale: Pursuant to the Official Disability Guidelines, continuous passive motion (CPM) the left shoulder is not medically necessary. CPM is not recommended for shoulder rotator cuff problems, but is recommended as an option for adhesive capsulitis, up to four weeks/5 times per day. CPM is not recommended before or after shoulder surgery or for nonsurgical treatment. In this case, the injured worker's working diagnoses are symptomatic traumatic rotator cuff tear, impingement; and syndrome and distal clavicle arthrosis left shoulder. The treatment recommendation section states the MRI shows evidence of pathology of internal derangement of the shoulder joint. The treating provider recommends arthroscopic rotator cuff repair, acromioplasty and distal clavicle resection. Current complaints include ongoing left shoulder pain aggravated with attempted lifting, reaching or pushing. Range of motion is decreased and abduction, internal and external rotation. The guidelines do not recommend CPM before or after shoulder surgery. CPM is not recommended for rotator cuff problems. There was no clinical discussion, indication or clinical rationale in the treatment plan for continuous passive motion of the left shoulder. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and guideline non-recommendations, continuous passive motion (CPM) the left shoulder is not medically necessary.