

<b>Case Number:</b>	CM15-0021838		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	12/29/2010
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2015

### 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

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 (IW) is a 60 year old male who sustained an industrial injury on 12/29/2010. He has reported ongoing pain in his left shoulder. Diagnoses include bilateral shoulder tendinitis, superior labral anterior posterior (SLAP) tear, and degenerative arthritis. Treatment to date includes an arthroscopy and repair for the right shoulder in March 2014. A progress note from the treating provider dated 12/05/2014 details ongoing shoulder pain on the left side. Review of the Magnetic Resonance Imaging of the left shoulder on 10/23/2014 showed evidence of a superior labral tear with Para-labral cyst, large in nature. Fraying and thinning of the supraspinatus was noted. Flexion and abduction was 140 degrees. The shoulder had crepitus with range of motion. Therapy had been ineffective and the IW did not want to try cortisone shot because it did not work on his opposite shoulder on which he had arthroscopic surgery on 03/15/2014. Treatment plans were made for arthroscopy, possibility of superior labral repair, acromioplasty with synovectomy on the left shoulder. On 01/15/2015 Utilization Review modified a request for Post-operative CPM (Continuous Passive Motion) machine for the left shoulder, rental for 30 day to rental for 7 days. The Official Disability Guidelines were cited. On 01/15/2015 Utilization Review non-certified a request for Post-operative cold therapy unit for the left shoulder 30 day rental or purchase to rental for 7 days post-operative. The Official Disability Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative cold therapy unit for the left shoulder 30 day rental or 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), Treatment Index, 13th Edition, 2015, Shoulder, 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, Shoulder, Continuous flow Cryotherapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder Cryotherapy. According to ODG Shoulder Chapter, Continuous flow Cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case there the recommendation exceeds the guidelines recommendation of 7 days. Therefore the determination is for non-certification.

**Post-operative CPM (Continuous Passive Motion) machine for the left shoulder, rental 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), Treatment Index, 13th Edition, 2015, Shoulder, 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, Shoulder, Continuous passive motion (CPM).

**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 exam note of 12/5/14, the determination is for non-certification.