

Case Number:	CM15-0027532		
Date Assigned:	03/27/2015	Date of Injury:	09/10/2010
Decision Date:	05/01/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/13/2015

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: Illinois, California, Texas
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 41-year-old female who sustained an industrial injury on 9/10/10. The mechanism of injury was not documented. She underwent a rotator cuff debridement, subacromial decompression with bursectomy, and right shoulder injection on 5/24/11. The 12/8/14 treating physician report indicated the patient was scheduled for surgery. Physical exam documented shoulder range of motion as flexion 160, abduction 160, external rotation 40, and internal rotation 90 degrees. There was weakness with external rotation and abduction at 3+ to 4-/5, and pain over the biceps tendon. The diagnosis was right shoulder impingement syndrome, rotator cuff recurrent tear, and rotator cuff tendinitis. She subsequently underwent right shoulder arthroscopic acromioclavicular joint decompression, Mumford procedure, subacromial decompression, rotator cuff debridement and labral debridement on 12/9/14. The 2/4/15 utilization review certified the right shoulder arthroscopy with rotator cuff repair, and subacromial decompression. The associated request for Polar care unit was modified to 7 day rental. The request for continuous passive motion (CPM) was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polar Care Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following shoulder surgery. The 2/4/15 utilization review decision recommended partial certification of a Polar care unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

Continuous Passive Motion (CPM) Rental x 21 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); Shoulder Chapter, 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: Continuous passive motion (CPM).

Decision rationale: The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is not recommended for shoulder rotator cuff problems or after shoulder surgery, except in cases of adhesive capsulitis. Guideline criteria have not been met. There is no current evidence that this patient has adhesive capsulitis. Prophylactic use of continuous passive motion in shoulder surgeries is not consistent with guidelines. Therefore, this request is not medically necessary.