MAXIMUS Federal Services

Case Number:	CM15-0029873		
Date Assigned:	02/23/2015	Date of Injury:	01/28/2011
Decision Date:	04/14/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/17/2015

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
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50 year old female, who sustained an industrial injury on January 28, 2011. She has reported left shoulder pain, lower back pain, and bilateral knee pain. The diagnoses have included rotator cuff syndrome and impingement syndrome of the left shoulder. Treatment to date has included medications, cortisone injections of the left shoulder, physical therapy, home exercise, and imaging studies. A progress note dated December 16, 2014 indicates a chief complaint of continued left shoulder pain with numbness and triggering of the left fingers and thumb, bilateral hand pain, numbness and stiffness, and lower back pain. Physical examination showed decreased range of motion of the bilateral shoulders, left greater than right. The treating physician requested a sling, cold therapy unit pad, home exercise kit, and a continuous passive motion machine. On January 26, 2015 Utilization Review certified the request for the sling and cold therapy unit pad and denied the request for the home exercise kit and continuous passive motion machine citing the California Medical Treatment Utilization Schedule California Chronic Pain Medical treatment Guidelines and American College of Occupational and Environmental Medicine Guidelines. On February 17, 2015, the injured worker submitted an application for IMR of a request for the home exercise kit and continuous passive motion machine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Exercise Kit: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter, exercise kit.

Decision rationale: The patient presents with pain and weakness in her shoulder and bilateral knees. The patient is s/p carpal tunnel release. The request is for HOME EXERCISE KIT. The patient is currently not working. MRI of the left shoulder from 10/31/14 revealed mild tendinosis of the supraspinatus tear with mild fraying along the bursal surface, mild tendinosis of the subscapularis tendon; mild degenerative changes of the acromioclavicular joint and mild lateral downsloping of the acromion compatible with mild increased anatomic risk for subacrominal impingment Exercise is recommended in MTUS, ACOEM, and ODG guidelines. ODG also support "exercise kit" under shoulder chapter. "Home exercise kits are recommended where home exercise and active self-directed home physical therapy is recommended." In this case, the treater requested for home exercise kit as post-op care following her left shoulder arthroscopy. Given the strong support for exercise in general, and a specific recommendation for exercise kit found under shoulder chapter, the current request appears reasonable. The patient does present with shoulder pain as well. The request IS medically necessary.

Continuous Passive Motion Machine: 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, 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 Chapter, Continuous passive motion (CPM) devices.

Decision rationale: The patient presents with pain and weakness in her shoulder and bilateral knees. The patient is s/p carpal tunnel release. The request is for CONTINUOUS PASSIVE MOTION MACHINE. The ACOEM and MTUS do not discuss Continuous passive motion (CPM) devices. ODG Shoulder Chapter has the following regarding continuous passive motion devices, "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." ODG further states, "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." In this case, the treater requested for CPM machine postoperatively following a left shoulder arthroscopy and rotator cuff repair if indicated. ODG guidelines does not support CMP machine for shoulder rotator cuff problems or after shoulder surgery. The request does not meet the guideline recommendations. Therefore, the request IS NOT medically necessary.