

<b>Case Number:</b>	CM15-0042699		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	04/20/2013
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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 48-year-old female, who sustained an industrial injury on April 20, 2013. The injured worker had reported a right shoulder injury with pain radiating to the neck, back and right arm. The diagnoses have included cervical disc syndrome, right rotator cuff syndrome, lumbar facet syndrome, right shoulder impingement, right medial epicondylitis and right carpal tunnel syndrome. Treatment to date has included medications, cortisone injections, physical therapy and right shoulder surgery on January 20, 2015. Current documentation dated January 26, 2015 notes that the injured worker complained of right shoulder and right arm pain. Physical examination of the right shoulder revealed tenderness and spasms of the deltoid on the right and a decreased range of motion. An empty can test and impingement tests were positive. The treating physician's recommended plan of care included a request for a continuous passive motion unit for the right shoulder, 30-day rental.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CPM unit for the right shoulder, 30- day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, shoulder chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter online, Continuous passive motion (CPM).

**Decision rationale:** Per the 02/24/15 report the patient presents with right shoulder pain s/p rotator cuff repair-unspecified date. The current request is for CPM UNIT FOR THE RIGHT SHOULDER, 30 DAY RENTAL per the 01/15/15 RFA. ODG-TWC guidelines, Shoulder Chapter online, under Continuous passive motion (CPM) states "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." The 01/05/15 report by states this request is for home use after surgery for up to 30 days to allow the joint to stay mobile and not allow scar tissue to build up. The patient's listed diagnoses are: Pain in Joint, Other affection of shoulder region, not elsewhere classified. In this case, CPM is not recommended for rotator cuff problems. The request IS NOT medically necessary.