

Case Number:	CM15-0045653		
Date Assigned:	03/18/2015	Date of Injury:	09/10/2012
Decision Date:	04/23/2015	UR Denial Date:	03/03/2015
Priority:	Standard	Application Received:	03/10/2015

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, South Carolina

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Family Practice

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 61-year-old female, who sustained an industrial injury on September 10, 2012. The diagnoses have included bilateral impingement syndrome of the shoulders, bilateral lateral epicondylitis, bilateral DeQuervains stenosing tenosynovitis, bilateral carpal tunnel syndrome, status post right shoulder arthroscopy, SAD and bursectomy, and status post right carpal tunnel release. Treatment to date has included Tramadol. Currently, the injured worker complains of left shoulder pain. In a progress note dated January 26, 2015, the treating provider reports examination of the left shoulder revealed tenderness over the anterior capsule, as well as over the rotator cuff insertion site, and over the posterior scapular regions about her left shoulder, muscle spasms and myofascial trigger points were noted about the left upper trapezius and left posterior scapular muscles, decreased range of motion, and positive impingement sign. The plan per the treating physician is to have the injured worker undergo left shoulder arthroscopy, subacromial decompression, distal clavicle resection, and possible rotator cuff repair. On 3/3/2015, Utilization Review non-certified the requests for continuous passive motion unit for the left shoulder, 4 week rental, and a Micro Cool unit for left shoulder, 4 week rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuous Passive Motion unit for the left shoulder, 4 week 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, 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 (ODG) Shoulder (Acute & Chronic), Continuous passive motion (CPM).

Decision rationale: Regarding shoulder continuous passive motion (CPM), the MTUS is silent. However, the Official Disability Guidelines (ODG) state that CPM for shoulder rotator cuff problems is not recommended, but it is as an option for adhesive capsulitis. The medical records available for the injured worker indicate she is to undergo shoulder arthroscopy with associated procedures, but there is no mention of adhesive capsulitis. Therefore, per the ODG, the request for continuous passive motion unit for the left shoulder, 4-week rental, is not medically necessary and appropriate.

Micro Cool Unit for Left Shoulder, 4 week 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, 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 (ODG) Shoulder (Acute & Chronic), Cold compression therapy and Continuous-flow cryotherapy.

Decision rationale: Per the Official Disability Guidelines (ODG), cold compression therapy is not recommended in the shoulder, as there are no published studies. The ODG also states that continuous-flow cryotherapy is recommended as an option after surgery, and that postoperative use generally may be up to 7 days, to include home use. Postoperatively, continuous-flow cryotherapy has been proven to decrease pain, inflammation, swelling, and narcotic usage. In the case of this injured worker, continuous-flow cryotherapy may be beneficial, but compression therapy is not recommended per the guidelines. The request for 28 days is longer than the 7-day ODG recommendation. Therefore, the requested Micro Cool Unit for left shoulder, 4-week rental, is not medically necessary.