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| Case Number: | CM15-0054573 | | |
| Date Assigned: | 03/30/2015 | Date of Injury: | 08/25/2011 |
| Decision Date: | 05/07/2015 | UR Denial Date: | 03/13/2015 |
| Priority: | Standard | Application Received: | 03/23/2015 |

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: Minnesota, Florida
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 56 year old male, who sustained an industrial injury on 08/25/2011. He has reported injury to the left shoulder and low back. The diagnoses have included left shoulder sprain/strain; failed left rotator cuff repair with recurrent tearing; lumbar spondylosis with myelopathy; and cervical disc herniation with myelopathy. Treatment to date has included medications, diagnostics, physical therapy, and surgical intervention. Medications have included Tramadol, Ibuprofen, and Tylenol #3. A progress note from the treating physician, dated 02/23/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of constant sharp pain in the left shoulder; the pain radiates to the neck and down to the elbow; and pain in the entire back and right knee. Objective findings included palpable tenderness to the left shoulder acromioclavicular joint and anterior acromion; and decreased range of motion of the left shoulder. The treatment plan has included surgical intervention, a left shoulder rotator cuff repair, with possible acromioclavicular joint resection. Request is being made for associated surgical service: 4 week rental of continuous passive motion (CPM) for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: 4 week rental of continuous passive motion (CPM) for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous passive motion (CPM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous Passive Motion.

Decision rationale: ODG guidelines do not recommend continuous passive motion for shoulder rotator cuff problems but it is recommended as an option for adhesive capsulitis. The documentation does not indicate approval of the requested surgical procedure. Furthermore, the request as stated is for 4 week rental of continuous passive motion unit for a rotator cuff repair which is not supported by guidelines. As such, the medical necessity of the request has not been substantiated.