

<b>Case Number:</b>	CM13-0065287		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	11/30/2011
<b>Decision Date:</b>	03/31/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 54 year-old female patient sustained an injury after being struck in the right shoulder, neck and elbow by a door on 11/30/11 while employed by the [REDACTED]. Requests under consideration include CPM X 3 weeks, right shoulder and Pneumatic intermittent compression. Conservative care has included at least 24 sessions of physical therapy, medications, and steroid injections. Primary diagnoses include osteoarthritis of shoulder; right rotator cuff impingement; acromioclavicular sprain and strain; cervical spondylosis without myelopathy; and contusion of forearm. Shoulder arthroscopy had been previously recommended; however, the patient had declined. Current DME for Continuous passive motion device and pneumatic compression are now requested for apparent shoulder arthroscopic procedure performed on 11/15/13 by requesting provider per report of 11/19/13. Requests for DMEs were non-certified on 12/9/13 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CPM x 3 weeks, right shoulder:** 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), 2013 online - treatment of shoulder conditions--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 Chapter, Continuous Passive Motion (CPM), pg. 910

**Decision rationale:** The employee is s/p arthroscopic shoulder surgery on 11/15/13. Although ODG does recommend CPM for post knee surgery with restricted indications, it specifically states the CPM is not recommended for post shoulder surgeries as multiple studies have noted no difference in function, pain, strength or range of motion. Submitted reports have not demonstrated adequate support for the continuous passive motion unit post shoulder arthroscopy outside the recommendations of the guidelines. The Continuous Passive Motion (CPM) X 3 weeks, right shoulder is not medically necessary and appropriate.

**Pneumatic intermittent compression:** 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) - Treatment in Workers' Comp (TWC), Knee and Leg Procedure Summary, 9/25/2012.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Physical Therapy, Hip, pg. 260.

**Decision rationale:** This 54 year-old female patient sustained an injury after being struck in the right shoulder, neck and elbow by a door on 11/30/11 while employed by the [REDACTED]. Requests under consideration include CPM X 3 weeks, right shoulder and Pneumatic intermittent compression. Conservative care has included at least 24 sessions of physical therapy, medications, and steroid injections. Primary diagnoses include osteoarthritis of shoulder; right rotator cuff impingement; acromioclavicular sprain and strain; cervical spondylosis without myelopathy; and contusion of forearm. Shoulder arthroscopy had been previously recommended; however, the patient had declined. Current DME for Continuous passive motion device and pneumatic compression are now requested for apparent shoulder arthroscopic procedure performed on 11/15/13 by requesting provider per report of 11/19/13. The MTUS and ACOEM Guidelines are silent on DME requested; however, ODG does indicate that pneumatic compression may be effective in patients undergoing hip or knee replacement post warfarin anti-coagulant therapy and has weak evidence lacking clinically significant differences in outcome of passive mobilization versus no intervention under the forearm, wrist, and hand chapter. Guidelines are silent on use of pneumatic compression as treatment for post shoulder arthroscopy. Submitted reports have not adequately demonstrated medical necessity for this DME without comorbidity. The Pneumatic intermittent compression is not medically necessary and appropriate.