

<b>Case Number:</b>	CM15-0016040		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	08/26/2014
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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 51 year old male who sustained an industrial injury on 8/26/14 where he was thrown from a bucket, hit by rocks and was left hanging in the air resulting in pain in the right chest area. He was in intensive care, suffered a hemothorax and had chest tubes. After this he continued to improve for the remainder of the hospital stay. He currently complains of significant right shoulder pain causing him to use narcotics around the clock. He has been able to regain moderate shoulder flexibility in the 3 months after the accident. Current medications include diclofenac; docusate sodium and MS Contin. Diagnosis is shoulder pain; rib fracture. Diagnostics included shoulder radiographs revealing no acute abnormalities; MRI of the shoulder showed significant findings (per note 11/4/14) diffuse lateral tearing and surgery was recommended. Progress notes provided do not mention the requests for shoulder continuous passive motion (CPM) machine, rental 21 days; CMP pad, purchase; thermal compression unit, rental 21 days. On 1/15/15 Utilization Review non-certified the requests for shoulder continuous passive motion (CPM) machine, rental 21 days; CMP pad, purchase; thermal compression unit, rental 21 days citing ODG: Shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Shoulder CPM machine, rental 21 days: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 devices (CPM)

**Decision rationale:** This patient is status post right shoulder scope, labral repair, paralabral cyst resection, bicep tenodesis, and distal clavicle resection on 01/09/2015. The current request is for shoulder CPM machine, rental 21 days. MRI of the right shoulder from 09/26/2014 revealed moderate tendinosis of the supraspinatus and infraspinatus tendon, mild subluxation of the long head biceps tendon, degenerative labral tearing. The ACOEM and MTUS guidelines do not discuss continuous passive motion devices. Therefore, ODG guidelines were consulted. ODG, under its shoulder chapter, has the following regarding continuous passive motion devices (CPM), "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to four weeks/five days per week." ODG further states, "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." In this case, the medical reports reviewed do not document adhesive capsulitis, and the patient has recently undergone surgery for a labral repair. The ODG guidelines are clear that CPM devices are not recommended for rotator cuff problems. This request is not medically necessary.

**CPM pad, purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 devices (CPM)

**Decision rationale:** This patient is status post right shoulder scope, labral repair, paralabral cyst resection, bicep tenodesis, and distal clavicular resection on 01/09/2015. The treating physician has made a request for shoulder CPM machine 20-day rental. The current request is for CPM pad, purchase. The ACOEM and MTUS guidelines do not discuss continuous passive motion devices. Therefore, ODG guidelines was consulted. ODG, under its shoulder chapter, has the following regarding continuous passive motion device (CPM), "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to four weeks/five days per week." In this case, the patient does not meet the indication for the use of a continuous passive motion device, as he does not present with adhesive capsulitis; therefore, the requested CPM pad is not necessary. This request is not medically necessary.

**Thermal compression unit, rental 21 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder chapter, compression garments

**Decision rationale:** This patient is status post right shoulder scope, labral repair, paralabral cyst resection, bicep tenodesis, and distal clavicular resection on 01/09/2015. The current request is for a thermo compression unit, rental 21 days. The ODG-TWC, under the shoulder chapter, states for compression garments, "Not generally recommended in the shoulder." It appears this thermo compression unit is being requested to be utilized with the shoulder CPM device. In this case, ODG does not recommend compression wraps for the shoulder and the CPM device is not indicated for this patient. This request is not medically necessary.