

<b>Case Number:</b>	CM15-0172316		
<b>Date Assigned:</b>	09/14/2015	<b>Date of Injury:</b>	12/29/2000
<b>Decision Date:</b>	10/29/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 58 year old female, who sustained an industrial injury on 12-29-00. The injured worker was diagnosed as having status post right carpal tunnel release in 2014, status post left carpal tunnel release on 6-24-15 and right shoulder partial rotator cuff tendon tear. Medical records (2-16-15 through 4-9-15) indicated 9 out of 10 pain, forward flexion was 145-180 degrees and abduction was 180 degrees. The physical exam on 5-21-15 revealed forward flexion and abduction is 0-165 degrees with stiffness and pain at end ranges of motion. There is also a positive Neer and Hawkins test and strength is 3+ out of 5. Treatment to date has physical therapy included physical therapy x 12 sessions, a right shoulder cortisone injection on 4-9-15 and right shoulder surgery on 7-31-15. As of the PR2 dated 7-2-15, the injured worker reports right shoulder pain. Objective findings include forward flexion and abduction is 0-165 degrees with stiffness and pain at end ranges of motion. There is also a positive Neer and Hawkins test and strength is 3+ out of 5. The treating physician recommended a right shoulder diagnostic and operative arthroscopy. The treating physician requested a cold compression therapy x 14 day rental for the right shoulder, a compression pad purchase for the right shoulder, a SCPM x 21 day rental for the right shoulder and a CPM pad purchase. The Utilization Review dated 8-21-15, non-certified the request for a cold compression therapy x 14 day rental for the right shoulder, a compression pad purchase for the right shoulder, a SCPM x 21 day rental for the right shoulder and a CPM pad purchase.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Cold compression therapy x 14 day rental for the 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold Compression Therapy.

**Decision rationale:** The ODG states that cold compression therapy is not recommended for the shoulder, as there are no published studies. It may be an option for other body parts. The home application of cold packs is just as effective as those performed by a therapist. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

### **Compression pad purchase for the right shoulder: 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 (ODG) Cold Compression Therapy.

**Decision rationale:** The requested cold compression therapy unit is not medically necessary. Therefore, there is no need to purchase a compression pad for the right shoulder. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

### **SCPM x 21 day rental for the 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous passive motion (CPM).

**Decision rationale:** The post-operative continuous passive motion (CPM) unit is used to prevent adhesions, facilitate range of motion, and to improve recovery. According to the ODG, continuous passive motion (CPM) is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. In this case, the patient underwent right shoulder surgery for repair of a rotator cuff tear. CPM is not recommended after shoulder surgery. Medical necessity for the requested service has not been established. The requested service 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 (ODG) Continuous passive motion (CPM).

**Decision rationale:** The requested continuous passive motion (CPM) treatments for the right shoulder are not medically necessary. Therefore, there is no need for to purchase a CPM pad for the right shoulder. Medical necessity for the requested item has not been established. The requested item is not medically necessary.