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| Case Number: | CM15-0178568 | | |
| Date Assigned: | 09/18/2015 | Date of Injury: | 02/25/2015 |
| Decision Date: | 10/22/2015 | UR Denial Date: | 08/11/2015 |
| Priority: | Standard | Application Received: | 09/10/2015 |

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, Oregon, Washington
 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 60-year-old male who sustained an industrial injury on 02-25-2015. The injured worker was diagnosed with rotator cuff tear, right acromioclavicular joint arthritis and right subacromial bursitis. According to the primary treating physician's progress report on July 21, 2015, the injured worker continues to experience right shoulder pain with failed prior treatment including diagnostic testing with recent right shoulder magnetic resonance imaging (MRI) performed on August 10, 2015, activity modification, physical therapy (12 sessions), chiropractic therapy, home exercise program, recent right shoulder steroid injection and medications. Examination demonstrated anterior tenderness and decreased range of motion with marked painful crepitus. Impingement and cross arm tests were positive. Treatment plan consists of the authorization for right shoulder arthroscopy, subacromial decompression and acromioclavicular resection with pre-operative medical clearance, cold therapy for 1 week and post-operative physical therapy 3 times a week for 4 weeks. On August 3, 2015, the provider requested authorization for post-operative continuous passive motion (CPM) for one week. The Utilization Review determined the request for continuous passive motion (CPM) for one-week rental was not medically supported for rotator cuff tears on 08-11-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: CPM x 1 Week: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder.

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.

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. About adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis in the cited records, the determination is not medically necessary.