

Case Number:	CM15-0067441		
Date Assigned:	04/14/2015	Date of Injury:	05/06/2011
Decision Date:	05/14/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/08/2015

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 69 year old male, who sustained an industrial injury on 05/06/2011. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having status post fall, herniated nucleus pulposus of the cervical spine, herniated nucleus pulposus of the lumbar spine, impingement syndrome and rotator cuff tendinosis of left shoulder, and status post left rib fractures. Treatment to date has included physical therapy, steroid injections, acupuncture, chiropractic therapy, magnetic resonance imaging of the lumbar spine, and magnetic resonance imaging of the left shoulder. In a progress note dated 12/03/2014 the treating physician reports complaints of increasing left shoulder pain, stiffness, and weakness that radiates to the left side of the neck that is rated a nine to ten on a scale of zero to ten. The injured worker has complaints of frequent neck pain with associated headaches with a pain rating of an eight to nine on a scale of zero to ten. The injured worker also noted complaints of low back pain that is rated a seven to eight on a scale of zero to ten. The treating physician requested a Home Therapy Kit for post-operative care to assist with enhancing rehabilitation. The treating physician also requested a continuous passive motion machine (CPM) for post-operative care. Physician documentation from 03/11/2015 also noted the request for continuous passive motion machine to initiate immediate shoulder movement/range of motion post-operatively to prevent a frozen shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuous Passive Motion (CPM) pluse Soft Goods for 21 day rental: 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), Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Continuous Passive Motion (CPM), page 910.

Decision rationale: 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 note 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) plus Soft Goods for 21-day rental is not medically necessary and appropriate.

Home Exercise Kit: 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 ODG Treatment, Durable medical equipment (DME), pages 297-298, 309.

Decision rationale: Although the ACOEM guidelines do recommend daily exercises, submitted reports have not demonstrated any evidence to support the medical necessity for a home exercise kit versus simple inexpensive resistive therabands to perform isometrics and eccentric exercises. Exercise equipment is considered not primarily medical in nature and could withstand repeated use as rental or used by successive patients, which is not indicated here. The patient continues to participate in active physical therapy and should have received instructions for an independent home exercise program without the need for specialized equipment. The Home Exercise Kit is not medically necessary and appropriate.