

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/6/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/2/2013  
Date of Injury: 11/27/2012  
IMR Application Received: 7/29/2013  
MAXIMUS Case Number: CM13-0003970

- 1) MAXIMUS Federal Services, Inc. has determined the request for **CPM rental for 21 days is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **soft goods for upper extremity for CPM is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/5/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **CPM rental for 21 days** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **soft goods for upper extremity for CPM** is not **medically necessary and appropriate**.

### Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Preventive Medicine and Occupational Medicine, 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 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 treatments and/or services at issue.

### Expert Reviewer Case Summary:

All 254 pages of medical, insurance, and administrative records provided were reviewed.

The applicant, Mr. [REDACTED], is a represented [REDACTED] [REDACTED] employee who has filed a claim for chronic low back and shoulder pain reportedly associated with an industrial injury of November 27, 2012.

Thus far, he has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; right shoulder arthroscopy on June 14, 2013; electrodiagnostic testing of March 7, 2013, notable for an L5 radiculopathy; and extensive periods of time off of work.

Specifically reviewed is a prior Utilization Review Report of July 2, 2013, denying Continuous Passive Motion (CPM) device, on the grounds that this is not recommended by a dated (non-current) version of the Official Disability Guidelines (ODG).

Also reviewed is an operative report of June 14, 2013, in which the applicant undergoes a diagnostic arthroscopy, synovectomy, chondroplasty, and debridement to ameliorate preoperative diagnosis of partial rotator cuff tear, labral tear, synovitis, and impingement syndrome.

Multiple prior shoulder surgery preoperative notes are reviewed, including notes of March 14, 2013, April 25, 2013, May 2, 2013, and June 6, 2013. There is no specific mention made of an operating diagnosis of adhesive capsulitis for which Continuous Passive Motion (CPM) would be indicated.

Operating diagnosis stated by the applicant's shoulder surgeon includes shoulder tendinosis and partial thickness rotator cuff tears.

It is further noted that the applicant's shoulder range of motion is consistently described in 155 degree range bilaterally, further arguing against adhesive capsulitis.

**Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for CPM rental for 21 days :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Shoulder Procedure Summary (updated 3/7/13), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 3rd Edition, Chapter 9), Specific Disorders, Adhesive Capsulitis, Education, Exercise, and Therapy and the Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Continuous passive motion (CPM), which are not part of the MTUS.

Rationale for the Decision:

As noted in the Third Edition ACOEM Guidelines, Continuous Passive Motion machines are recommended in the treatment of adhesive capsulitis. In this case, the documentation submitted for review does not support an operating diagnosis of adhesive capsulitis. Operating diagnoses includes rotator cuff tendinosis and partial thickness rotator cuff tears, for which Continuous Passive Motion is not recommended either by ACOEM or by the most current Official Disability Guidelines (ODG) Guidelines. ODG, like ACOEM, endorses continuous passive motion in the treatment of adhesive capsulitis, but not rotator cuff tendinosis/rotator cuff tears, as appear to be present in this case. Therefore, the request remains non-certified on independent medical review. **The request for CPM rental for 21 days is not medically necessary and appropriate.**

**2) Regarding the request for soft goods for upper extremity for CPM :**

Since the CPM rental is not medically necessary, none of the associated accessories are medically necessary.

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.