

<b>Case Number:</b>	CM13-0018354		
<b>Date Assigned:</b>	03/21/2014	<b>Date of Injury:</b>	10/11/2011
<b>Decision Date:</b>	04/23/2014	<b>UR Denial Date:</b>	08/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Shoulder and Elbow Surgery, 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 47-year-old male who reported an injury on October 11, 2011. The mechanism of injury was not stated. The patient is currently diagnosed with sprain/strain of the neck, sprain/strain of the lumbar spine and rotator cuff tear. The patient was seen by [REDACTED] on August 12, 2013. The patient reported persistent pain. Physical examination revealed tenderness to palpation with spasm and weakness in the cervical spine, lumbar spine and left shoulder. Treatment recommendations at that time included authorization for a left shoulder mini open rotator cuff repair and subacromial decompression, postoperative physical therapy, a shoulder sling and an ice therapy unit. It was noted that the patient underwent an MRI of the left shoulder on January 11, 2012, which indicated tendinosis of the rotator cuff with a small tear and SLAP deformity of the glenoid labrum with impingement syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **30 POST OPERATIVE PHYSICAL THERAPY VISITS BETWEEN 7/19/2013 AND 11/4/2013: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 26-27.

**Decision rationale:** The Post-Surgical Treatment Guidelines state the initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. Postsurgical treatment following a rotator cuff repair includes thirty visits over eighteen weeks for an open repair and 24 visits over fourteen weeks for an arthroscopic repair. As per the documentation submitted, the patient was issued authorization for an arthroscopic surgery of the left shoulder, to include a mini open rotator cuff repair and subacromial decompression. However, the current request for thirty postoperative physical therapy visits exceeds guideline recommendations. The request for thirty post-operative physical therapy visits are not medically necessary or appropriate.

**1 POST OPERATIVE SHOULDER SLING WITH ABDUCTION PILLOW BETWEEN 7/19/2013 AND 10/4/2013: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**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, Postoperative Abduction Pillow Sling.

**Decision rationale:** The Official Disability Guidelines state that a postoperative abduction pillow sling is recommended as an option following an open repair of large and massive rotator cuff tears. As per the documentation submitted, the patient's MRI documented on January 11, 2012 indicated a small tear of the rotator cuff. The patient has been authorized to undergo a left shoulder arthroscopy with mini open rotator cuff repair and subacromial decompression. Therefore, the patient does not appear to meet the criteria for the requested postoperative DME. The request for one post-operative shoulder sling with abduction pillow is not medically necessary or appropriate.

**1 CRYOTHERAPY UNIT BETWEEN 7/19/2013 AND 10/4/2013: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**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 Flow Cryotherapy.

**Decision rationale:** The Official Disability Guidelines state that continuous flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to seven days. While it is noted that the patient has received authorization to undergo a left shoulder arthroscopic/mini open rotator cuff repair and subacromial decompression, guidelines only recommend the use of continuous flow cryotherapy for up to seven days. Therefore, the request

cannot be determined as medically appropriate. The request for one cryotherapy unit is not medically necessary or appropriate.