

<b>Case Number:</b>	CM13-0028245		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	05/24/2012
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	09/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 48-year-old female who reported an injury on 05/24/2012. The mechanism of injury was a slip and fall on her back twisting her left knee. The injured worker has a history of shoulder pain. Upon examination on 12/03/2013, the injured worker was status post right shoulder arthroscopy surgery on 10/17/2013. Upon exam of the right shoulder, there was diffuse tenderness. The range of motion was forward elevation was 120 degrees, abduction was 110 degrees, internal rotation was 70 degrees, and external rotation was 80 degrees. Upon examination on 06/17/2014, the injured worker presented with multiple complaints, which include cervical spine, bilateral shoulder, left back, and bilateral knee pain, status post right shoulder and left knee arthroscopy surgery. The injured worker continued to be symptomatic. Upon exam of the right shoulder, there was positive impingement syndrome, positive Hawkins test, and tenderness to the greater tuberosity. The range of motion was forward elevation was 160 degrees, abduction was 150 degrees, internal rotation was 70 degrees, and external rotation was 80 degrees. The injured worker has diagnoses of cervical spine pain/strain with underlying multilevel arthrosis with degenerative disc protrusion and multilevel annular tear with spinal stenosis, grade 1 retrolisthesis at C4-5 and C5-6; right shoulder partial rotator cuff tear at the articular surface less than 20%; right shoulder degenerative labral; right shoulder glenoid fossa chondromalacia type IV (small area); left shoulder impingement syndrome - improved; low back pain/radiculitis with mild disc protrusion; right knee mild to moderate arthritis/internal derangement; left knee lateral meniscus tear; left knee chondromalacia of the patella, trochlea, and lateral femoral condyle type II through IV. A list of diagnostic studies was not provided. Prior treatments included physical therapy and acupuncture, epidural steroid injections, steroid injections, surgery, medications, heating pad, icing, and TENS Unit. Medications included Diflucan and Carisoprodol. The injured worker's average pain is an 8/10. The pain is in the right

shoulder and arm with tingling and sometimes shooting down to the elbow. Right shoulder pain also migrates to the left shoulder and neck that ranges between a 7/10 to a 7.5/10. The Request for Authorization form and rationale for the request were not provided within the documentation submitted for review. An MRI of the right shoulder on 09/21/2012 showed mild degenerative changes seen involving the AC joint and there was mild degenerative changes seen involving the humerus. There was mild thinning and atrophy on the supraspinatus tendon and the abnormal signal seen in the supraspinatus possibly represented a partial tear.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **POST-OP RIGHT SHOULDER PHYSICAL THERAPY 3 X 8 WEEKS QTY: 24.00:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The request for postop right shoulder physical therapy 3 times 8 weeks quantity 24 is non-certified. The injured worker is postop right shoulder surgery on 10/17/2013. The injured worker had a history of right shoulder pain. The California MTUS Guidelines recommend postsurgical physical therapy treatment for up to 24 visits. There needs to be documentation of functional improvements while using the therapy. The injured worker has received prior physical therapy for an unknown number of visits. There is a lack of documentation as to the improvement of functional deficit for the right shoulder. Also, without the amount of visits already received, an assessment of being excessive cannot be established. As such, the requests for postop right shoulder physical therapy 3 times 8 weeks quantity 24 is not medically necessary.

#### **1 POST-OP RIGHT SHOULDER PAIN PUMP: 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) Shoulder, Postoperative pain pump.

**Decision rationale:** The request for 1 postop right shoulder pain pump is non-certified. The injured worker is postop right shoulder surgery on 10/17/2013. The Official Disability Guidelines state the use of postoperative pain pump is not recommended. The quality or CTs did not support the use of pain pumps. There is no significant evidence to conclude that direct infusion is as effective or more effective than conventional pre or postoperative pain control using oral, intramuscular, or intravenous measures. The guidelines do not recommend the use of pain pumps. As such, the request for postop right shoulder pain pump is not medically necessary.

## **1 POST-OP RIGHT SHOULDER COLD THERAPY UNIT: 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) Shoulder, Cold compression therapy.

**Decision rationale:** The request for postop right shoulder cold therapy unit is non-certified. The injured worker is postop right shoulder surgery on 10/17/2013. The Official Disability Guidelines state that cold compression therapy is not recommended in the shoulder as there are no published studies. There are no guidelines to support the use of cold therapy. As such, the request is not medically necessary.

## **1 POST-OP RIGHT SHOULDER CPM MACHINE: 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) Shoulder, Continuous passive motion (CPM).

**Decision rationale:** Decision for the request for postop right shoulder CPM machine is non-certified. The injured worker is postop right shoulder surgery on 10/17/2013. The Official Disability Guidelines state that use of continuous passive motion is not recommended for shoulder rotator cuff problems but recommended as an option for adhesive capsulitis up to 4 weeks, 5 days per week. CPM is not recommended for surgery or for nonsurgical treatment. There were no guidelines to support the use of the CPM machine for shoulder surgery. The request for postop right shoulder CPM machine is not medically necessary.