

Case Number:	CM13-0050716		
Date Assigned:	12/27/2013	Date of Injury:	12/13/2010
Decision Date:	10/02/2014	UR Denial Date:	10/14/2013
Priority:	Standard	Application Received:	11/14/2013

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 and is licensed to practice in Indiana. 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 57-year-old female who has a history of bilateral shoulder pain, neck pain, and back pain after an industrial motor vehicle accident on 12/13/10. The injured worker initially was treated by a chiropractor and physical therapy and massage. Because of continuing left shoulder pain, her treating physician ordered an MRI of the left shoulder which revealed a laterally downsloping acromion process, OA of the AC joint, supraspinatus tendinosis, and a full thickness tear with retraction of the vertical portion of the biceps tendon with an effusion and subacromial/subdeltoid bursal fluid. The injured worker complains of left shoulder pain, stiffness, weakness, and tenderness. The worker has received conservative treatment consisting of Celebrex, Tramadol, acupuncture, PT, electrical stimulation, NSAIDs, and rest without significant improvement. An examination of the left shoulder was reported as revealing 160 degrees of forward flexion, 40 degrees of extension, 160 degrees of abduction, 40 degrees of adduction, and 60 degrees of external rotation. The worker also has a positive compression test, impingement sign, Speed's test and O'Brien's test with painful ROM, subacromial crepitus, and tenderness. The treating physician diagnosed the injured worker with a shoulder sprain, left shoulder impingement and left proximal biceps tendon disruption and surgery for an arthroscopic left shoulder decompression, distal clavicle resection, and rotator cuff debridement and/or repair has previously been found to be medically necessary. The treating physician is requesting approval for: 18 sessions of post-operative physical therapy, a 45 day rental of a post-operative continuous passive motion device, a 90 day rental of a post-operative electrical stimulation unit, and a post-operative cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Postoperative physical therapy sessions, 3x6 weeks: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute and Chronic), Physical Therapy: Sprained Shoulder/Rotator Cuff

Decision rationale: According to MTUS for Post-Surgical treatment for Rotator Cuff/ Impingement Syndrome, post-surgical physical therapy is felt to be medically necessary for 24 visits over 14 weeks. The same number of physical therapy visits are also felt to be necessary according the ODG Guidelines for a Sprained Shoulder/Rotator cuff s/p RC repair/acromioplasty. Therefore, the requested physical therapy visits are medically necessary.

Postoperative continuous passive motion (CPM) device for 45 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, Continuous Passive Motion

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute and Chronic), Physical Therapy: Sprained Shoulder/Rotator Cuff

Decision rationale: The MTUS are silent regarding the use of CPM after shoulder surgery. According to the ODG guidelines for the use of CPM after rotator cuff surgery, the use of CPM after shoulder surgery is not recommended and with regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. Therefore, the rental of a post-operative continuous passive motion device is not medically necessary.

Postoperative electrical stimulation unit, 90 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS Page(s): 116.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute and Chronic), Electrical Stimulation

Decision rationale: According to the ODG guidelines for the shoulder, electrical stimulation is not recommended due to a lack of efficacy. Therefore, the requested post-operative electrical stimulation is not medically necessary.

Postoperative 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: Cryotherapy

Decision rationale: According to ODG guidelines, continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. Because the treating physician has not defined the length of use of the post-operative cold therapy unit in the request, the post-operative cold therapy unit is not medically necessary.