

<b>Case Number:</b>	CM14-0003317		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	11/07/2011
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	12/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2014

### 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 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 an employee of [REDACTED] and has filed a claim for pes anserine tendinitis associated with an industrial injury date of November 7, 2011. Treatment to date has included left shoulder rotator cuff repair, postoperative physical therapy, shoulder injections, and pain medications. Medical records from 2013 were reviewed showing the patient being approved for left shoulder surgery - manipulation under anesthesia with arthroscopic rotator cuff debridement versus repair, subacromial decompression and distal clavicle excision. The patient has been complaining of persistent left shoulder pain despite physical therapy and shoulder injections. Activities of daily living are affected due to pain. On examination, the left shoulder range of motion was noted to be limited. Motor testing was limited due to pain; motor strength was decreased for the left shoulder. Provocative tests for impingement such as Hawkins and cross adduction maneuvers were noted to be painful. Neurovascular examination for the left upper extremity was normal. Utilization review from December 11, 2013 modified the request for 24 postoperative therapy to 12 postoperative therapy. The request for cold therapy unit rental and purchase was modified to a 7-day rental. &#8195;

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE COLD THERAPY UNIT FOR PURCHASES FOR RENTAL BETWEEN 12/9/2103 AND 1/23/2014:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 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 cyrotherapy

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Shoulder chapter, Continuous flow cyrotherapy was used instead. The Official Disability Guidelines (ODG) state that continuous-flow cyrotherapy is an option after surgery and can be used for up to 7 days. In this case, the patient will be undergoing left shoulder surgery. However, cold therapy units are only recommended for 7 days as a rental with no other support for a purchase. There is no discussion concerning the need for a purchase and the documentation. Therefore, the request for cold therapy unit for rental is not recognized as medically necessary beyond 7 days from the date of surgery. The request is not medically necessary and appropriate.

**TWENTY-FOUR (24) POST-OPERATIVE OCCUPATIONAL THERAPY VISITS:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SHOULDER COMPLAINTS.

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

**Decision rationale:** California MTUS postsurgical treatment guidelines for rotator cuff/impingement syndrome states that postsurgical treatment is recommended at 24 visits over 14 weeks. However, an "initial course of therapy" is recommended at one half the recommended amount (i.e. 12 visits) In this case, the patient will undergo rotator cuff surgery. However, the requested amount of postsurgical therapy visits exceeds the recommended initial course of therapy. Therefore, while the request for 24 postoperative occupational therapy visits is not medically necessary.