

<b>Case Number:</b>	CM14-0019436		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	01/25/2012
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	01/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/15/2014

### 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:

38 year old claimant with reported industrial injury 1/25/12. Exam note from 1/10/14 demonstrates complaint of right shoulder pain. Examination demonstrates decreased right shoulder range of motion. Diagnosis of cervical desiccation, sprain of shoulder, cervical radiculopathy, myofascial pain, poor coping and sleep issues. Right shoulder MRI 2/23/12 demonstrates subscapularis tendinopathy with possible small surface tear, proximal bicipital tendinopathy anterior to humeral head, no rotator cuff tear, no fracture and no labral tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **POST-OPERATIVE PHYSICAL THERAPY, #12: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of postsurgical treatment visits allowable are: Rotator cuff syndrome/Impingement syndrome/Postsurgical treatment, arthroscopic: 24 visits over 14 weeks Postsurgical physical medicine treatment period: 6 months Postsurgical treatment, open: 30

visits over 18 weeks Postsurgical physical medicine treatment period: 6 months The guidelines recommend certifying half of the recommended visits initially. Therefore the 12 visits are medically necessary as it is a half of 24 visits.

**SHOULDER BRACE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute and Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for Rotator Cuff Repair.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of a shoulder brace. Per ODG criteria, immobilization is recommended following open rotator cuff repair. As there is no indication of need for open rotator cuff repair in the cited records then the request is not medically necessary.

**ABDUCTION PILLOW:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute and Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, surgery for rotator cuff repairs.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of abduction pillow. Per the ODG criteria, abduction pillow is recommended following open repair of large rotator cuff tears but not for arthroscopic repairs. In this case there is no indication for need for open rotator cuff repair and therefore the request is not medically necessary.

**COLD THERAPY UNIT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute and Chronic).

**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-flow cryotherapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow Cryotherapy, it is recommended

immediately postoperatively for upwards of 7 days. 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. In this case there is no specification of length of time requested postoperatively for the Cryotherapy unit. Therefore the request is not medically necessary.