

Case Number:	CM14-0041970		
Date Assigned:	06/30/2014	Date of Injury:	10/03/2012
Decision Date:	07/30/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/09/2014

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 Physical Medicine and Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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 71-year-old female with a date of injury of 10/03/2012. The listed diagnoses per treating physician are, right shoulder adhesive capsulitis, right shoulder partial rotator cuff tear and impingement syndrome, status post right total knee arthroplasty and right elbow strain. According to progress report 03/04/2014 by the treating physician, the patient presents with right shoulder, right elbow, and right knee pain. The right shoulder pain is most severe. The patient was administered a corticosteroid injection 3 months ago which only provided temporary improvement. The examination of the shoulder revealed pain on palpation of the subacromial bursa and subdeltoid bursa on the right. There is significant decrease of range of motion in all planes on the right. The treating physician states the patient has severe adhesive capsulitis as well as high-grade partial thickness rotator cuff. The patient is indicative for surgery. The treating physician recommends right shoulder arthroscopic subacromial decompression, lysis of adhesions, and manipulation under anesthesia. He also requests postoperative medical clearance, postoperative physical therapy 3 times a week for 6 weeks, cold therapy unit device (rental or purchase), and a continuous passive motion machine (rental or purchase).

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op physical therapy for right shoulder: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment Guidelines, Acromioclavicular Joint Dislocation chapter.

Decision rationale: This patient presents with adhesive capsulitis and partial rotator cuff tear and impingement syndrome of the right shoulder. The patient has been approved for the requested right shoulder arthroscopy and subacromial decompression on 04/01/2014. The treating physician is requesting postop physical therapy 3 times a week for 6 weeks. The MTUS post-surgical guidelines page 26-27 recommends 24 visits over 14 weeks for arthroscopic surgery. The requested 18 post operative physical therapy sessions is medically necessary and recommendation is for approval.

Cold therapy unit (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non- MTUS Citation ODG-TWC.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Official Disability Guidelines (ODG), Continuous-Flow Cryotherapy chapter.

Decision rationale: This patient presents with adhesive capsulitis and partial rotator cuff tear and impingement syndrome of the right shoulder. The patient has been approved for the requested right shoulder arthroscopy and subacromial decompression on 04/01/2014. The treating physician is requesting a rental or purchased of cold therapy unit. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, the ODG are referenced. The ODG has the following regarding continuous-flow cryotherapy, it's 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 use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated. The MTUS Guideline recommends the duration of postoperative use of continuous-flow cryotherapy to be 7 days. The use of the cold therapy unit outside of the postoperative 7 days is not medically necessary, and given there are no discussions on the duration of use, recommendation is for denial.

CPM (continuous passive motion) machine/kit (rental or purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Official Disability Guidelines (ODG), Continuous Passive Motion (CPM) chapter.

Decision rationale: This patient presents with adhesive capsulitis and partial rotator cuff tear and impingement syndrome of the right shoulder. The patient has been approved for the requested right shoulder arthroscopy and subacromial decompression on 04/01/2014. The treating physician is requesting a continuous passive motion machine/kit (CPM) for rental or purchase. The ACOEM and MTUS do not discuss Continuous passive motion devices. Therefore, the ODG guidelines were consulted. The ODG under its shoulder chapter has the

following regarding continuous passive motion devices, not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The ODG further states, rotator cuff tears is not recommended after shoulder surgery or for nonsurgical treatment. Recommendation is for denial. As such, the request is not medically necessary.