

Case Number:	CM14-0078319		
Date Assigned:	07/18/2014	Date of Injury:	08/02/2013
Decision Date:	08/15/2014	UR Denial Date:	05/13/2014
Priority:	Standard	Application Received:	05/28/2014

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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 59 year old male with a work injury dated 8/2/13 .The diagnoses include status post right shoulder arthroscopy with subacromial decompression and rotator cuff repair performed on 12/2/13 . The patient has now had pain and stiffness of the shoulder unresponsive to greater than 3 months of physical therapy and home exercises program and underwent a right manipulation under anesthesia on 6/14/14. Under consideration is a request for 8 physical therapy visits and one cold therapy unit. Per documentation 8 sessions of physical therapy were approved on 4/25/2014. There is a primary treating physician (PR-2) document dated 4/8/14 that states that the patient has recurrent symptoms six weeks status post right subacromial decompression with rotator cuff repair. On exam the range of motion with forward flexion was 0 to 80; external rotation was 0-30 and internal rotation to T12. There is stiffness. The treatment plan includes a request for manipulation under anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Physical Therapy Visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy Guidelines, Adhesive capsulitis, Post surgical treatment, Shoulder (Acute and Chronic).

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

Decision rationale: 8 Physical Therapy Visits is not medically necessary per the MTUS Postsurgical and ODG guidelines. The MTUS Postsurgical guidelines do not address the medical treatment of physical therapy for adhesive capsulitis. The ODG guidelines state that the medical treatment for adhesive capsulitis is 16 visits of PT over 8 weeks. The documentation indicates that the patient was already approved for 8 visits on 4/25/14. Without objective physical therapy notes of objective functional improvement an additional 8 cannot be recommended. Therefore the request for 8 physical therapy visits is not medically necessary.

1 Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy. Decision based on Non-MTUS Citation Continuous flow cryotherapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous-flow cryotherapy shoulder.

Decision rationale: 1 Cold Therapy Unit is not medically necessary per the ACOEM MTUS and the ODG guidelines. The ACOEM shoulder chapter recommends at home applications of cold packs if needed for shoulder pain. The ODG guidelines state that 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. The documentation is not clear on why this cold therapy system is required. The procedure of manipulation under anesthesia is not considered a surgery. The request does not indicate a duration. The request for 1 Cold Therapy Unit is not medically necessary.