

Case Number:	CM14-0085930		
Date Assigned:	08/06/2014	Date of Injury:	07/11/2008
Decision Date:	09/10/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/09/2014

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 Orthopedic Surgery, has a subspecialty in Orthopedic Sports Medicine and is licensed to practice in Texas. 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 52 year old female whose date of injury is 07/11/2008 to the left shoulder. The mechanism of injury is undisclosed. Treatment to date includes right upper extremity Bier block, cortisone injections, physical therapy and medication management. The injured worker has been authorized for left shoulder arthroscopy, possible arthroscopic versus open decompression with acromioplasty, rotator cuff debridement versus repair, resection of coracoacromial ligament and/or bursa, twelve postoperative physical therapy visits, cold therapy unit for seven days use, large abduction pillow, and assistant surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Post Operative Physical Therapy Visits for the Left Shoulder, 3 Times Per Week for 6 Weeks.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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

Decision rationale: The injured worker has been authorized to undergo left shoulder arthroscopy with twelve visits of postoperative physical therapy. California Medical Treatment Utilization

Schedule (MTUS) guidelines would support an initial trial of twelve postoperative physical therapy visits to establish efficacy of treatment and assess the injured worker's response to treatment. The injured worker's objective, functional response to this treatment is not documented, and therefore medical necessity of eighteen postoperative physical therapy visits is not established. Based on the clinical information provided, the request for eighteen Postoperative Physical Therapy visits for the Left Shoulder, three times per week for six weeks is not medically necessary.

Cold Therapy Unit, 14 Days Rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Continuous Flow Cryotherapy.

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 cryotherapy.

Decision rationale: The Official Disability Guidelines would support continuous flow cryotherapy for up to seven days in the postoperative period, and there is no rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. Based on the clinical information provided, the request for Cold Therapy unit fourteen day rental is not medically necessary.

E-Stimulator, 14 Days Rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines interferential stimulation, pages 118-120 Page(s): 118-120.

Decision rationale: There are no specific, time limited treatment goals provided. The injured worker's response to prior conservative treatment is not documented. Therefore, the request for E stimulator fourteen days rental is not in accordance with California Medical Treatment Utilization Schedule (MTUS) guidelines, and medical necessity is not established. Based on the clinical information provided, the request for E-Stimulator fourteen days rental is not medically necessary.

Continuous Passive Motion Unit, 30 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 (Acute & Chronic) Continuous Passive Motion (CPM).

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 passive motion (CPM).

Decision rationale: The injured worker has been authorized to undergo left shoulder arthroscopy. The Official Disability Guidelines (ODG) note that continuous passive motion is not supported for rotator cuff problems, but may be recommended as an option for adhesive capsulitis which is not documented in the submitted clinical records. The (ODG) state that for rotator cuff tears, continuous passive motion is not recommended after shoulder surgery or for nonsurgical treatment. Based on the clinical information provided, the request for Continuous Passive Motion unit thirty day rental is not medically necessary.

Home Care Post-Operative, 24-Hours per Day for 3 Weeks, then 8 Hours Per Day for 3 Weeks, and then 2 Hours per Day for an Additional 3 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Care.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services, page 51 Page(s): 51.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) guidelines would support home health services for injured workers who are homebound on a part time or intermittent basis. The submitted clinical records fail to establish that this injured worker is homebound on a part time or intermittent basis. Based on the clinical information provided, the request for home care postoperative twenty four hours per day for three weeks, then eight hours per day for three weeks, and then two hours per day for an additional three weeks is not medically necessary.