

<b>Case Number:</b>	CM14-0090381		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	06/18/2012
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	06/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2014

### 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:

This 43-year-old female inventory/receiving clerk sustained an industrial injury on 6/18/12, relative to repetitive work duties. Past surgical history was positive for left shoulder surgery on 2/28/13. The 8/16/13 right shoulder MRI reportedly showed a partial rotator cuff tear and acromioclavicular (AC) joint impingement. The 2/19/13 right shoulder x-rays demonstrated 1+ calcification of the subscapular insertion, type II acromion, and mild AC joint impingement. The treating physician progress reports indicated the patient had right shoulder pain with popping. Pain increased with reaching backwards and above shoulder level and lying on her side. Pain had recently increased with physical therapy. Right shoulder exam findings documented anterior capsular and deltoid tenderness with positive impingement test. Range of motion testing noted abduction 80-100 and forward flexion 165 degrees. There was 4-/5 supraspinatus, infraspinatus, and biceps strength noted. The diagnosis was right shoulder calcific subscapularis tendinopathy, partial rotator cuff tear, and impingement syndrome. Conservative treatment had included medication, physical therapy, cortisone injection, and activity modification. The treatment plan included right shoulder arthroscopic surgery, biceps repair, AC joint surgery, labral repair, and rotator cuff repair. The 6/4/14 utilization review denied the surgical and associated requests as there was insufficient evidence relative to imaging and response to cortisone injection to establish the medical necessity of surgery. There is no indication as to the status of the shoulder surgery request in the file.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arc Sling (purchase):** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204,213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter,Immobilization.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213.

**Decision rationale:** The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request for purchase of an arc sling is medically necessary.

**Cold Therapy Unit - purchase or rental for 14 days:** 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 Chapter, 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, Continuous flow cryotherapy.

**Decision rationale:** The California MTUS is silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery. Postoperative use is generally supported up to 7 days, including home use. This request for cold therapy unit purchase or 14-day rental is not consistent with guidelines. There is no compelling reason to support the medical necessity of cold therapy beyond guideline recommendations. Therefore, this request for cold therapy unit purchase or 14-day rental is not medically necessary.

**12 Sessions of Physical Therapy to right Shoulder (3xper week for 4 weeks):** Overturned

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

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

**Decision rationale:** The California MTUS Post-Surgical Treatment Guidelines for rotator cuff repair/impingement syndrome suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This request for initial post-operative treatment is consistent with guidelines. Therefore, the request for 12 sessions of physical therapy for the right shoulder (3x4) is medically necessary.