

Case Number:	CM14-0203119		
Date Assigned:	12/15/2014	Date of Injury:	06/08/2010
Decision Date:	02/26/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/04/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Utah, California
 Certification(s)/Specialty: Orthopedic Surgery

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 51-year-old female with a date of injury on 06/08/2010. The mechanism of injury was not indicated. Her relevant diagnoses included right shoulder pain and rotator cuff tendinitis, left de Quervain's tendinitis. Past treatments include therapy and medication. Diagnostic studies included an MRI of the right shoulder on 08/29/2014, which revealed a full thickness rotator cuff tear that measured approximately 1.5 cm in the AP joint direction with lateralized acromion and moderate AC joint hypertrophy. On 11/11/2014, it was noted the injured worker complained of pain with use of her right arm in flexion, extension, and attempts at overhead use, as well as repetitive gripping and grasping. Objective physical findings upon examination of the right shoulder included pain on palpation of the subacromial space and distal clavicle with discomfort in the AC joint. There was increased pain with flexion to 160 degrees, abduction 70 degrees, external rotation 60 degrees, with impingement sign positive in the Hawkins position. Her medications consist of Norco 10/325 mg up to 4 a day, duration unknown. The treatment plan is surgery of the right shoulder and 24 visits of postoperative physical therapy, as well as cryotherapy for 1 week. The request is for (1) scope with rotator cuff repair, (2) decision for scope with distal clavicle excision (Mumford) of the right shoulder, (3) associated surgical service of initial postop physical therapy evaluation for the right shoulder, (4) associated surgical service for initial postop physical therapy, unspecified frequency for the right shoulder of 24 sessions, (5) associated surgical service 1 cold pack, (6) decision for associated surgical service of an assistant surgeon, (7) associated surgical service the rental of a cryotherapy unit, and (8) decision for associated surgical service of a sling of the right shoulder.

The rationale is following right shoulder arthroscopy with rotator cuff repair. Surgical history includes lumbar surgery on 01/25/2012, shoulder surgery in 2012, ear surgery in 2008, wrist surgery in 2010, and knee surgery in 2011. The Request for Authorization form was not included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Initial post-op physical therapy, unspecified frequency for the right shoulder; 24 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): (s) 26-27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Office Visits

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

Decision rationale: The request for associated surgical service: Initial post-op physical therapy, unspecified frequency for the right shoulder; 24 sessions is not medically necessary. The California MTUS recommend postoperative physical therapy. The surgical intervention has been authorized therefore physical therapy would be indicated. However, the provider request for physical therapy for the right shoulder of 24 sessions would exceed the guideline recommendations. The guidelines would recommend an initial course of 12 visits of postop physical therapy. As such, the provider's request exceeds the guideline recommendations. As such, medical necessity has not been established.

Associated surgical service: one cold pack: 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, cold packs

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Cold packs 9.

Decision rationale: The request for associated surgical service: one cold pack is not medically necessary. The injured worker presented with pain in her shoulder. The Official Disability Guidelines recommend cold packs have a beneficial effect on range of motion, function, and strength. Cold packs decrease swelling. The California MTUS/ACOEM Guidelines state that at home applications of heat or cold packs are recommended to aid in exercises. There is no evidence that cold pack would be recommended over at home applications. The provider does not provide a rationale for the requested cold pack. As such, medical necessity has not been established.

