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| Case Number: | CM15-0000314 | | |
| Date Assigned: | 01/09/2015 | Date of Injury: | 12/13/2012 |
| Decision Date: | 03/06/2015 | UR Denial Date: | 12/19/2014 |
| Priority: | Standard | Application Received: | 01/02/2015 |

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: Maryland, Virginia, North Carolina
 Certification(s)/Specialty: Plastic 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:

This 56 year old female was injured 12/13/12. The mechanism of injury was not clear. The injured worker has a long history of pain symptoms and conservative modalities such as therapy and medications are exhausted but she continues to experience residual pain. Current symptoms included increased pain in wrist and hand and left shoulder tenderness. Current diagnoses include left shoulder chronic subacromial impingement syndrome; degenerative joint disease, severe, left acromioclavicular joint; superior labrum degenerative type I SLAP tear; partial thickness bursal surface rotator cuff tear. She underwent arthroscopic left shoulder subacromial decompression; arthroscopic distal clavicle resection (Mumford procedure); extensive debridement of superior degenerative type I SLAP tear and extensive debridement of partial-thickness bursal surface rotator cuff tear. Treatment includes physical/ occupational therapy for left shoulder and home exercise program. A request for post-operative physical therapy was submitted along with a cold therapy unit but reason was not clearly documented. On 12/19/14 Utilization Review non-certified the request for post-operative physical therapy (PT) 2X4 based on no documentation of objective benefit from previous sessions or a rationale as to why additionally supervised PT would be required versus her home exercise program. There is no clear documentation of musculoskeletal deficits that cannot be addressed within the context of an independent home exercise program, yet would be expected to improve with formal supervised therapy. MTUS Chronic Pain Guidelines were referenced. The request for Cold Therapy Unit & tot rent was non-certified the rationale was not clear. ODG did address cold therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Services- 8 sessions of Post-Op Physical Therapy to left shoulder (2x4 weekly): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

Decision rationale: The patient is a 56 year old female who had undergone left shoulder surgery on 9/10/14 which included arthroscopic left shoulder subacromial decompression; arthroscopic distal clavicle resection (Mumford procedure); extensive debridement of superior degenerative type I SLAP tear and extensive debridement of partial-thickness bursal surface rotator cuff tear. The patient is noted to have undergone post-operative physical therapy and a home exercise program. The patient is noted to continue to have relevant pain symptoms, but was noted to have continued improvement as on an evaluation dated 12/2/14. The patient is noted to have undergone surgical treatment for degenerative joint disease and impingement syndrome. Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks Postsurgical physical medicine treatment period: 6 months. Based on these guidelines, the patient is still within the treatment period and may require additional physical therapy, but the number of already completed visits was not available from the medical records reviewed. If this information can be provided, additional physical therapy could be reconsidered.

Associated Surgical Services- Cold therapy unit; purchase: 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) Carpal Tunnel Syndrome

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Continuous cold therapy

Decision rationale: The patient is a 56 year old female who had undergone left shoulder surgery on 9/10/14. A request was made for continuous cold therapy unit for purchase. It is unclear the exact purpose for this device. From ODG, continuous cold therapy may be used in the post-operative setting with regular assessment to avoid frostbite. However, post-operative use should generally be no more than 7 days. Thus, without further justification from the requesting physician and documentation with regards to its specific use, this should not be considered medically necessary.

