

Case Number:	CM15-0105220		
Date Assigned:	06/09/2015	Date of Injury:	12/08/2013
Decision Date:	07/13/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/01/2015

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: California, Indiana, Oregon
 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 38 year old male, who sustained an industrial injury on 12/8/2013. He reported falling and injuring his head, neck, back and left arm. Diagnoses have included right shoulder partial thickness versus small full thickness rotator cuff tear, right shoulder acromioclavicular joint arthrosis, right shoulder pain and dysfunction and right shoulder impingement. Treatment to date has included physical therapy, right shoulder injection, medications and a home exercise program. According to the progress report dated 5/6/2015, the injured worker complained of right shoulder pain and dysfunction. Exam of the right shoulder revealed positive Speed's and positive impingement. Right shoulder magnetic resonance imaging (MRI) showed downsloping anterolateral acromion, acromioclavicular joint arthrosis, rotor cuff tendinosis with a small partial thickness tear and small subchondral cysts. Authorization was requested for right shoulder surgery and related services including post-operative physical therapy and polar care unit rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Post-Op Physical Therapy Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

Decision rationale: Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of postsurgical treatment visits allowable are: Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks. The guidelines recommend "initial course of therapy" to mean one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in the guidelines. In this case the requested amount exceeds the guideline recommendations. The request is not medically necessary.

Associated Surgical Service: Polar Care Unit Rental (Weeks) Qty 2: 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).

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, is recommended immediately postoperatively for up to 7 days. In this case the requested duration exceeds the guideline recommendations and the request is therefore not medically necessary.