

Case Number:	CM15-0189663		
Date Assigned:	10/01/2015	Date of Injury:	06/08/2012
Decision Date:	11/16/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	09/25/2015

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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 male who sustained an industrial injury June 8, 2012. Past treatment included facet nerve block right L3-4 and L4-5 at the level of the medial branches October, 2013, radiofrequency ablation right L4-5 and L5-S1 December 26, 2013, right L4-5 and L5-S1 diagnostic facet block at medial branches at L3 and L4 and dorsal primary ramus L5 December 30, 2013, radiofrequency ablation facet joint right L4-5 and L5-S1 medial branches L3-4 and dorsal primary ramus of L5 February 24, 2014. Diagnoses are cervical spine sprain, strain with possible derangement; clinical bilateral upper extremity radiculopathy; right shoulder sprain, strain; tendinitis and bursitis, right shoulder; lumbar spine sprain, strain with possible internal derangement. According to an orthopedic physician's re-evaluation dated August 17, 2015, the injured worker presented with ongoing complaints of pain and stiffness to his cervical spine radiating down both arms. He also complains of persistent and increasing pain and stiffness to his right shoulder and continued pain and stiffness to his lumbar spine radiating down the right leg. He reported abdominal and groin pain. Physical examination revealed; cervical and lumbar spine unchanged from previous visit; right shoulder- tenderness to palpation over the proximal humerus region; impingement testing is positive on the right; range of motion is limited-flexion 146 degrees, extension 24 degrees, abduction 137 degrees, adduction 19 degrees, internal rotation 64 degrees and external rotation 58 degrees; weakness to the right shoulder on flexion and abduction; sensory response over C5, C6 and C7 nerve roots, within normal limits right and left; biceps, triceps and brachioradialis reflexes are normal and equal bilaterally. The physician documented an MRI of the right shoulder dated July 2, 2014, impression as; glenohumeral joint

effusion, mild degree of fluid in the subacromial bursa with subacromial bursitis; increased signal at the musculotendinous junction of the supraspinatus tendon compatible with tendinosis and reactive peritendinitis associated with subacromial bursitis, findings consistent with bicipital tendinitis. The physician also documented an ultrasound of the testicles dated July 29, 2014, impression; a right scrotal hydrocele. At issue, are the requests for authorization for a cold therapy unit, UltraSling and post-operative physical therapy 12-18 visits. According to utilization review dated September 18, 2015, the requests for right shoulder arthroscopy with subacromial decompression, acromioplasty, debridement and bursectomy, pre-operative laboratory work, and chest x-ray were certified. The request for post-operative physical therapy (12) to (18) visits were modified to (12) visits of physical therapy. The request for a cold therapy unit was modified to a cold therapy unit rental for (7) days. The request for UltraSling is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative physical therapy 12-18 visits: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

Decision rationale: The patient presents with pain and stiffness to the cervical spine radiating down both arms, pain and stiffness to the right shoulder, continued pain and stiffness to his lumbar spine radiating down the right leg, abdominal pain, and groin pain. The current request is for Post-operative physical therapy 12-18 visits. The treating physician states, in a report dated 08/17/15, postoperatively, he will require 12-18 visits of physical therapy (10B). The patient is scheduled to undergo right shoulder arthroscopy with subacromial decompression, acromioplasty, debridement and bursectomy. The PSTG guidelines state, postsurgical treatment, arthroscopic: 24 visits over 14 weeks within a six month period. In this case, the treating physician, based on the records available for review, has not documented any prior physical therapy, and 12-18 visits fall within the 24 visits recommended by the guidelines for arthroscopy. The current request is medically necessary.

Associated surgical service: Cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter (updated 2/27/15).

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 patient presents with pain and stiffness to the cervical spine radiating down both arms, pain and stiffness to the right shoulder, continued pain and stiffness to his

lumbar spine radiating down the right leg, abdominal pain, and groin pain. The current request is for associated surgical service cold therapy unit. The treating physician states, in a report dated 08/17/15, postoperatively, he will require a cold therapy unit (10B) The MTUS guidelines are silent on cold therapy units. ODG guidelines support continuous-flow cryotherapy only after surgery as an option for up to 7 days. In this case, no length of time has been specified for use of the unit post surgically. Additionally, a UR decision letter dated 09/18/15 has modified certification of cold therapy unit rental for 7 days. As such, the current request is not medically necessary.

Associated surgical service: Ultrasling: 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).

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

Decision rationale: The patient presents with pain and stiffness to the cervical spine radiating down both arms, pain and stiffness to the right shoulder, continued pain and stiffness to his lumbar spine radiating down the right leg, abdominal pain, and groin pain. The current request is for associated surgical service Ultrasling. The treating physician states, in a report dated 08/17/15, postoperatively, he will require use of an Ultrasling. (10B) The MTUS guidelines are silent on the use of Ultrasling. ODG guidelines state, recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. In this case, the treating physician, based on the records available for review, has documented that this is an arthroscopic repair to the shoulder, which is not supported by the guidelines. The current request is not medically necessary.