

Case Number:	CM15-0212883		
Date Assigned:	11/02/2015	Date of Injury:	03/18/2014
Decision Date:	12/15/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/29/2015

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: Illinois, California, Texas
 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:

This injured worker is a 59-year-old male who sustained an industrial injury on 3/18/14. Injury occurred when he lost his balance and fell to the right side, landing on his shoulder. He underwent a right ankle arthroscopy with synovectomy on 9/3/15 and a right shoulder arthroscopic with subscapularis and supraspinatus tendon repairs, acromioplasty and Mumford procedure on 11/12/14. He had completed post-op physical therapy over approximately 6 months with injections noted in March and June 2015. The last documented physical therapy note in the medical records was on 5/1/15. The 7/31/15 right shoulder MRI impression documented adequate post-operative appearance of the rotator cuff repair without evidence of a recurrent rotator cuff tear. There was acromioclavicular joint decompression without evidence of deltoid dehiscence. There was joint capsule thickening without additional features of adhesive capsulitis. The 8/17/15 initial orthopedic consult cited constant grade 2-3/10 right shoulder pain with limited range of motion and popping. He reported decreased right arm strength and noted it was very painful to carry more than 10 pounds. He reported difficulty in scrubbing his back in the shower and occasional right arm numbness. He was performed exercises for his shoulder with elastic bands 2 to 3 times daily. He also reported grade 2/10 right foot and ankle pain with intermittent numbness and swelling. He had difficulty standing or walking longer than 10 minutes, or walking more than 2 blocks. Shoulder exam documented no swelling or atrophy, and 1+ pain with palpation over the posterior acromion, levator scapula, trapezius, and impingement area. Range of motion was reported as flexion 140, abduction 140, external rotation 20, and internal rotation 20 degrees. There was 4/5 strength and pain with resisted

external rotation, internal rotation, and supraspinatus testing. There was 4/5 global right shoulder strength. Right ankle exam documented pain to palpation over the anterolateral and medial gutters, anterior talofibular ligament, and peroneal tendons. Range of motion was limited in eversion and inversion. He was unable to heel or toe walk. There was positive instability with varus stress and anterior drawer testing. The diagnosis included posttraumatic right shoulder adhesive capsulitis with some stiffness and weakness, and persistent right ankle distal avulsion of the fibula and peroneal brevis tear with continued pain and limping. The treatment plan recommended right shoulder physical therapy to address range of motion, stretching and strengthening exercises, and right ankle revision arthroscopy. Authorization was requested for right ankle arthroscopy, debridement, resection of loose fragment, modified Brostrom procedure, exploration of peroneal tendon and associated surgical services including Percocet 5-325mg #60, CAM walker boot purchase, crutches purchase, pre-op evaluation including blood work and EKG, and ice machine rental. Authorization was also requested for 12 visits of physical therapy for the right shoulder and right ankle. The 10/1/15 utilization review certified the right ankle arthroscopy, debridement, resection of loose fragment, modified Brostrom procedure, and exploration of peroneal tendon, and associated requests for Percocet 5-325mg #60, post-op physical therapy 2x6 for the right ankle, CAM walker boot purchase, crutches purchase, and pre-op evaluation including blood work and EKG. The request for an ice machine rental was non-certified as there was no guidelines support for these units following ankle/foot surgery over standard cold packs. The request for 12 visits of physical therapy for the right shoulder was non-certified as there was no detailed documentation of the number of physical therapy visits to date or objective and functional improvement with the prior treatment to support additional physical therapy treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Ice machine (7-day rental): Upheld

Claims Administrator guideline: Decision based on MTUS Ankle and Foot Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guideline (ODG), TWC Ankle & Foot Procedure Summary Online Version last updated 03/26/2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot: Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous flow cryotherapy is not recommended in ankle complaints. Guidelines support the use of applications of cold packs. There is no compelling rationale presented to support the medical necessity of a cold therapy unit over standard ice packs and as an exception to guidelines. Therefore, this request is not medically necessary

Physical therapy, 2 times a week for 6 weeks for the right shoulder (12-sessions):
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Physical therapy.

Decision rationale: California MTUS Post-Surgical Treatment Guidelines do not apply to this case as the 6-month post-surgical treatment period had expired. MTUS Chronic Pain Medical Treatment Guidelines would apply. The MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The Official Disability Guidelines recommend 16 visits of physical therapy over 8 weeks for a diagnosis of adhesive capsulitis. This injured worker has persistent right shoulder pain, weakness and limited range of motion. There is significant loss of external and internal rotation consistent with adhesive capsulitis. There is no evidence of recent conservative treatment directed at the right shoulder. Home exercise for the right shoulder is noted with elastic bands, which would address strengthening but not range of motion. There is functional loss that would support another course of physical therapy. This request is within guideline recommendations. Therefore, this request is medically necessary.