

Case Number:	CM15-0220096		
Date Assigned:	11/13/2015	Date of Injury:	07/15/2014
Decision Date:	12/24/2015	UR Denial Date:	11/02/2015
Priority:	Standard	Application Received:	11/09/2015

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 35-year-old male who sustained an industrial injury on 7/15/14. Injury occurred when his right hand/wrist was smashed between a forklift and the forklift fork. He underwent right wrist-elbow exploration, transposition of the ulnar nerve at the elbow, and Guyon's canal release on 7/14/15. The 8/5/15 right shoulder MRI demonstrated a near full thickness, partial width supraspinatus tear on a background of severe tendinosis. There was a high-grade partial thickness articular sided tear extending into the junction of the supraspinatus and infraspinatus with 17 mm of medial retraction, moderate infraspinatus and subscapularis tendinosis, labral tear, and moderate acromioclavicular (AC) joint osteoarthritis. The 9/17/15 treating physician report cited persistent and increasing right shoulder pain, stiffness and weakness. He was not working. Right shoulder exam documented tenderness to palpation over the anterior aspect, acromion process, AC joint and coracoid region. Right shoulder range of motion was limited to flexion 100, extension 20, abduction 95, adduction 15, external rotation 55, and internal rotation 65 degrees. There was a positive arc of motion. Neer and thumb down testing were positive. The diagnosis included right shoulder tendinitis/impingement syndrome with significant rotator cuff tear. The injured worker had completed physical therapy, medications, and activity modification with on-going pain and symptoms. Authorization was requested for right shoulder arthroscopy with subacromial decompression, acromioplasty, and rotator cuff repair with associated surgical requests including cold therapy unit rental 6 weeks and 12-18 visits of post-op physical therapy. The 11/2/15 utilization review certified the requested right shoulder surgery. The request for 6 week rental of a cold therapy unit was modified to a one week rental consistent with the Official Disability Guidelines. The request for 12-18 visits of post-op physical therapy was modified to 12 initial post-op physical therapy visits consistent with Post-Surgical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Cold Therapy Unit Rental 6 Weeks: 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: Continuous flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 11/2/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7- day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

Post-Op Physical Therapy 12-18 Visits: Upheld

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

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for impingement syndrome and rotator cuff repair suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 11/2/15 utilization review recommended partial certification of 12 initial post-op physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of care beyond guideline recommendations and the care already certified. Therefore, this request is not medically necessary.