

<b>Case Number:</b>	CM15-0030125		
<b>Date Assigned:</b>	03/27/2015	<b>Date of Injury:</b>	09/25/2003
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	02/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 67-year-old male who reported an injury on 09/25/2003. The mechanism of injury was not specified. His diagnoses included right shoulder degenerative disease. Past treatments include surgery and corticosteroid injections and physical therapy. Diagnostic studies included an official MRI of the right shoulder performed on 12/20/2014, read by [REDACTED] which was noted to reveal moderate cuff tendinosis without recurrent tear with degeneration of superior labrum and thinning of the articular cartilage of the humeral head, interval tenodesis of the biceps tendon identified with interosseous ganglion or cystic change in the glenoid bone, chronic scarring from the previous tear of the posterior labrum to the posterior glenoid posterior superior to posterior inferior quadrant with intact inferior glenohumeral ligament labral complex anteriorly. His surgical history included a right shoulder arthroscopy on 02/09/2015. On 02/05/2015, the injured worker complained of right shoulder pain rated at a 6/10 to 7/10, exacerbated with range of motion and relieved with immobilization and rest. The physical examination revealed full range of motion of the neck, negative Spurling's, and biceps, triceps, grip, and interosseous are 5/5 strength. Radial pulses were 2+ and symmetric. There is limited range of motion of the right shoulder versus the left. He has pain with rotator cuff stress testing and weakness with belly press. Current medications were not specified. The treatment plan included prescription for postoperative medication and surgery. A request was received for slingshot brace, Polar Ice machine, remaining 2 sessions of physical therapy, and postoperative health care. The rationale for the request was not documented. The Request for Authorization form was not submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Slingshot brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The Official Disability Guidelines do not recommend immobilization as primary treatment as early mobilization benefits include earlier return to work, decreased pain, swelling, and stiffness, and greater preserved range of motion with no increased complications. The clinical information indicated the injured worker underwent arthroscopy of the right shoulder on 02/09/2015. However, as the evidence based guidelines do not recommend the use of immobilization, the request is not supported. Therefore, the request for sling shot brace is not medically necessary.

**Associated surgical service: Polar Ice Machine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 Official Disability Guidelines recommend the use of continuous flow cryotherapy postoperatively for up to 7 days. The clinical information indicated the injured worker underwent arthroscopy of the right shoulder on 02/09/2015. However, the request as submitted did not specify a frequency of use for the machine. Given the absence of the information indicated above, the request is not supported. Therefore, the request for Polar Ice Machine is not medically necessary.

**Associated surgical service: Physical Therapy x 8-10:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The Official Disability Guidelines recommend up to 24 visits of postsurgical treatment following shoulder surgery. The clinical information indicated the injured worker underwent arthroscopy of the right shoulder on 02/09/2015. However, clarification is needed of when the patient began physical therapy, how many sessions were completed to date, and evidence of quantified functional improvement with therapy, as the request is for remaining sessions. Given the absence of the information indicated above, the request is not supported. Therefore, this request is not medically necessary.

**Post-Operative Home Health Care (unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Service Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines, [www.cdg-twc.com/odgtwc](http://www.cdg-twc.com/odgtwc).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

**Decision rationale:** The California MTUS Guidelines recommend home health services for patients who are home bound on a part time or intermittent basis. The clinical information indicated the injured worker underwent arthroscopy of the right shoulder on 02/09/2015. However, there was no documentation of a physical examination following surgery to indicate the injured worker was to be home bound on a part time or intermittent basis. In addition, the request as submitted did not specify the duration of home health needed. Given the absence of the information indicated above, the request is not supported. Therefore, the request for Post op home health care is not medically necessary.