

Case Number:	CM15-0034845		
Date Assigned:	03/03/2015	Date of Injury:	01/31/2014
Decision Date:	04/15/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/24/2015

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:

The injured worker is a 59-year-old male, who sustained an industrial injury on 1/21/14. The patient underwent right shoulder rotator cuff repair on 7/31/14 with a cold therapy unit dispensed. Records indicated that he completed 24 post-op physical therapy sessions and two post-operative corticosteroid injections. The 12/11/14 treating physician report cited persistent right shoulder pain with significant limitation in range of motion and strength. Physical exam documented flexion 125, abduction 100, and internal/external rotation 45 degrees, with 4/5 strength. The treatment plan recommended right shoulder arthroscopy with manipulation under anesthesia. The 1/28/15 utilization review certified the requests for right shoulder arthroscopy with manipulation under anesthesia, surgical assistant, pre-operative testing, post-op medication, and ARC brace. The requests for post op physical therapy 2x12 and post op cold compression purchase were modified to physical therapy x 12 initial sessions only and a new wrap only for a previously dispensed cold therapy unit. The MTUS and ODG Guidelines were cited. On 2/24/15, the injured worker submitted an application for IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post op physical therapy 2x12: Upheld

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

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for adhesive capsulitis 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. 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 1/28/15 utilization review recommended partial certification of 12 post-operative physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of additional care beyond initial guideline recommendations. Therefore, this request is not medically necessary.

Post op cold compression purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Continuous flow Cryotherapy.

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

Decision rationale: The California MTUS is silent regarding cold compression units. The Official Disability Guidelines do not recommend cold compression therapy in the shoulder but state that continuous-flow cryotherapy is an option for up to 7 days. Records documented that the patient had been dispensed a cold therapy unit with the 7/31/14 surgery. The 1/28/15 utilization review modified the request for a cold compression unit to approve a new wrap to be used with the previously dispensed cold therapy unit. There is no compelling reason to support additional certification in the absence of guideline support for a cold compression unit. Therefore, this request is not medically necessary.