

Case Number:	CM15-0048399		
Date Assigned:	03/20/2015	Date of Injury:	11/11/2014
Decision Date:	05/01/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	03/13/2015

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

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 32 year old male who sustained an industrial injury on 11/11/2014. Diagnoses include left labral tear, and left arthritic acromioclavicular joint. Treatment to date has included physical therapy, chiropractic sessions, medications and diagnostic testing. A physician progress note dated 02/24/2015 documents the injured worker has pain in the left shoulder and limited range of motion in the left shoulder with forward elevations, and abduction. He has a positive labral grind test and has a normal cervical range of motion. The injured worker is to have a Superior Labrum Anterior and Posterior repair of left shoulder. Treatment requested is for post-operative Game ready unit (in days) QTY 20, and post-operative physical therapy QTY 12.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative Game ready unit (in days) QTY 20: 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) Treatment in Workers Compensation (TWC); ODG Treatment Integrated Treatment/Disability Duration Guidelines, Knee & Leg Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Continuous flow cryotherapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case, the request exceeds the guidelines recommendation of 7 days. Therefore, the determination is for non-certification. The requested treatment is not medically necessary.

Post-operative Physical Therapy QTY 12: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

Decision rationale: Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of postsurgical treatment visits allowable are: Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks. Postsurgical physical medicine treatment period: 6 months. Postsurgical treatment, open: 30 visits over 18 weeks. Postsurgical physical medicine treatment period: 6 months Sprained shoulder; rotator cuff (ICD9 840; 840.4): Postsurgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks. Postsurgical physical medicine treatment period: 6 months The guidelines recommend initial course of therapy to mean one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in the guidelines. In this case the request of 12 is 1/2 of the maximal allowable visits of 24. Therefore, the determination is for certification. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. Therefore, the requested treatment is medically necessary.