

<b>Case Number:</b>	CM15-0235833		
<b>Date Assigned:</b>	12/11/2015	<b>Date of Injury:</b>	02/19/2015
<b>Decision Date:</b>	01/20/2016	<b>UR Denial Date:</b>	11/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2015

### 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 69-year-old male who sustained an industrial injury on 2/19/15. Injury occurred while removing a bushing from the wheel disc of a bus, with onset of anterior right shoulder pain. The 4/28/15 right shoulder MRI impression documented a large retracted rotator cuff tear involving the supraspinatus and portion of the infraspinatus and subscapularis associated with muscle atrophy. The long head of the biceps tendon was torn and retracted. There were advanced degenerative changes at the acromioclavicular (AC) joint and moderate degenerative changes at the glenohumeral joint. The 6/29/15 right shoulder x-rays showed early degenerative changes of the glenohumeral joint with a calcar osteophyte. There were significant degenerative changes of the AC joint with significant narrowing of the supraspinatus outlet and slight elevation of the humeral head. The 11/4/15 treating physician report cited persistent grade 5-7/10 right shoulder pain, with limited range of motion and weakness. Functional difficulty was reported in lifting, pushing, or pulling heavy objects. He was not working. Right shoulder exam documented range of motion as flexion 120, abduction 130, and extension 40 degrees, and Apley's scratch test to L2. There was tenderness over the supraspinatus, subacromial, biceps tendons, and AC joint. There was 5/5 strength. Hawkin's, Neer's and Speed's tests were positive. Authorization was requested for right shoulder arthroscopy, debridement and possible rotator cuff repair with allograft and associated surgical requests including 24 visits of post-operative physical therapy and 14-day rental of a Game Ready cryotherapy unit. The 11/12/15 utilization review certified the request for right shoulder arthroscopy, debridement and possible rotator cuff repair with allograft. The request for 24 visits of post-op physical therapy was modified to 12 initial post-op visits consistent with Post-Surgical Treatment Guidelines. The request for a Game Ready cryotherapy unit for 14 day rental was non-certified as cold compression therapy is not guideline supported in the shoulder. A simple carpal tunnel release was recommended for 7-day certification.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**24 postoperative physical therapy sessions, 3 times a week for 8 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**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 11/12/15 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.

**Game ready cryo unit 14 day rental: 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), Shoulder, Postoperative continuous flow cryotherapy.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Cold compression therapy; Game Ready: accelerated recovery system.

**Decision rationale:** The California MTUS are silent regarding cold compression therapy. Cryotherapy is recommended using standard cold packs. The Official Disability Guidelines do not recommend cold compression therapy in for patients undergoing upper extremity surgeries. There is no evidence of improved clinical post-operative outcomes for patients using an active cooling and compression device over those using ice bags and elastic wrap after upper extremity surgery. There is no support for continuous flow cryotherapy over standard ice packs for the proposed surgery. There is no compelling reason in the records reviewed to support the medical necessity of a mechanical cold system over standard cold pack in the absence of demonstrated improved clinical efficacy. Therefore, this request is not medically necessary.