

Case Number:	CM14-0212151		
Date Assigned:	01/02/2015	Date of Injury:	09/27/2013
Decision Date:	02/20/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/18/2014

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 39-year-old male who reported an injury on 09/27/2013. The mechanism of injury reportedly occurred when the injured worker was pulling a 4 foot ladder from the back of his truck, when he felt a snap sensation in the middle of his back with radiating pain to the lumbar spine. His diagnoses included dorsal sprain/strain and sprain of lumbar region. Past treatments include medications. Diagnostic studies included an MRI performed on 05/19/2014, read by [REDACTED] which was noted to reveal mid disc desiccation, minimal loss of disc height, and a broad based left posterior/paracentrally protruded disc mildly encroaching upon the left S1 nerve root; and an MRI performed on 08/21/2014, read by [REDACTED] which was noted to reveal a near full thickness tear without overall retraction of the supraspinatus tendon as its attachment. On 11/17/2014, the injured worker was seen for re-examination. The patient complained of persistent right shoulder pain aggravated with activities at and above shoulder level. He also reported ongoing low back pain. The physical examination revealed full range of motion of the right shoulder with tenderness, 4/5 muscle strength in flexion and abduction, dorsal spine tenderness, decreased range of motion of the lumbar spine with paravertebral tenderness and spasm, straight leg raise negative, with normal sensation. Current medications were not specified. The treatment plan included authorization for right shoulder arthroscopic repair and a followup visit. A request was received for a right shoulder arthroscopy, postop physical therapy, continuous passive motion, cold therapy unit, and postop sling/immobilizer. The rationale for the request was not provided. The Request for Authorization form was dated 11/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for Rotator Cuff Repair.

Decision rationale: The request for right shoulder arthroscopy is not medically necessary. The Official Disability Guidelines state that the indications for a partial thickness rotator cuff repair would include: documentation of conservative care for at least 3-6 months; subjective findings, including pain with active arc motion 90 to 130 degrees and pain at night; objective findings, including weak or absent abduction, tenderness over the rotator cuff and positive impingement sign; and imaging findings to corroborate a rotator cuff tear. An MRI performed on 08/21/2014 revealed a near full thickness tear of the rotator cuff. There was also documentation with evidence of conservative care including medications. However, there was no documentation with evidence of pain with active arc motion 90 to 130 degrees, or pain at night. Given the absence of the information indicated above, the request is not supported. Therefore, the request for Right Shoulder Arthroscopy is not medically necessary.

Post-Operative Physical Therapy (amount unknown): Upheld

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

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

Decision rationale: The request for Post-Operative Physical Therapy is not medically necessary. There California MTUS guidelines recommend up to 24 visits of physical therapy for up to 6 months following rotator cuff/impingement syndrome surgery. However, as the right shoulder arthroscopy was not certified, the request for post op physical therapy is not supported. In addition, the request as submitted does not specify the exact number of physical therapy sessions needed. Therefore, the request for Post-Operative Physical therapy is not medically necessary.

Continuous passive motion (CPM): 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 Chapter, Continuous passive motion (CPM)

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 passive motion (CPM).

Decision rationale: The request for Continuous Passive Motion is not medical necessary. The Official Disability Guidelines no not recommend continuous passive motion after shoulder surgery or for nonsurgical treatment of rotator cuff tears. As the request is not recommended by the evidence based guidelines and as the right shoulder arthroscopy was not certified, the request is not supported. In addition, the request does not specify the duration of use for the continuous passive motion. Therefore, the request for Continuous Passive Motion is not medically necessary.

Cold therapy unit (unknown if rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Continuous flow cyrotherapy

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 request for Cold therapy unit is not medically necessary. The Official Disability Guidelines recommended continuous-flow cryotherapy as an option after surgery for up to 7 days, but not for nonsurgical treatment. However, as the right shoulder arthroscopy was not certified, the request is not supported. In addition, the request as submitted does not specify frequency of use. Therefore, the request for Cold Therapy Unit is not medically necessary.

Post-Operative Sling/Immobilizer: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Postoperative abduction pillow sling

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 request for Post-Operative sling/immobilizer is not medically necessary. The Official Disability Guidelines states that early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. However, as the request is not recommended by the evidence based guidelines and as the right shoulder arthroscopy was not certified, the request is not supported. In addition, the request as submitted does not specify the duration of use. Therefore, the request for Post-Operative Sling/Immobilizer is not medically necessary.