

Case Number:	CM14-0213353		
Date Assigned:	12/30/2014	Date of Injury:	11/02/2013
Decision Date:	03/03/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/19/2014

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

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 is a 61-year-old male with an 11/02/13 date of injury, when he injured his left shoulder while lifting a garbage can. The patient underwent left shoulder arthroscopy with rotator cuff repair and biceps tendonesis on 3/31/14. The progress note dated 06/26/14 stated that the patient accomplished 12 sessions of PT and the progress note dated 8/5/14 indicated that the patient was certified for additional 12 PT visits. The patient was seen on 11/18/14 with complaints of continued pain and limited function of the left shoulder. Exam findings of the left shoulder revealed: active flexion of 90 degrees, external rotation of 90 degrees, and internal rotation to L3. There was minimal pain with stressing of supraspinatus and the range of motion of the elbow was full. The request for a left shoulder revision repair surgery was made. The diagnosis is sprain of other specified sites of shoulder and upper arm and disorders of bursae and tendons in shoulder region. Treatment to date: left shoulder arthroscopy with rotator cuff repair and biceps tendonesis, work restrictions, PT, and medications. An adverse determination was received on 11/24/14 given that the current request for left shoulder arthroscopy with revision was not certified and the necessity for post-op left shoulder sling, post-op cold therapy unit and post-op PT was not established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: post-op left shoulder sling: Upheld

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

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

Decision rationale: CA MTUS does not address this issue. ODG states that postoperative immobilization is not recommended; immobilization is also a major risk factor for developing adhesive capsulitis, also termed "frozen shoulder". The progress report dated 11/18/14 stated that the request for a left shoulder revision repair surgery was made, however there is a lack of documentation indicating that the surgery was certified. In addition, the Guidelines do not support postoperative immobilization. Therefore, the request for post-op left shoulder sling was not medically necessary.

Associated surgical service: post-op cold therapy unit: 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, 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 Chapter, Continuous-flow cryotherapy.

Decision rationale: CA MTUS does not specifically address cold therapy unit for the shoulder. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. The progress report dated 11/18/14 stated that the request for a left shoulder revision repair surgery was made, however there is a lack of documentation indicating that the surgery was certified. Therefore, the request for post-op cold therapy unit was not medically necessary.

Associated surgical service: physical therapy for the left shoulder, 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99, Postsurgical Treatment Guidelines.

Decision rationale: CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. In addition, the Post-Surgical Treatment Guidelines recommend 24 visits over 14 weeks after arthroscopic postsurgical treatment of Rotator cuff syndrome/Impingement syndrome. The patient underwent left shoulder arthroscopy with rotator cuff repair and biceps tendonesis on 3/31/14. The progress report dated 11/18/14 stated that the request for a left shoulder revision repair surgery was made, however there is a lack of documentation indicating that the surgery was certified. Therefore, the request for physical therapy for the left shoulder, 2 times a week for 6 weeks was not medically necessary.