

<b>Case Number:</b>	CM15-0115543		
<b>Date Assigned:</b>	06/29/2015	<b>Date of Injury:</b>	02/07/2015
<b>Decision Date:</b>	07/28/2015	<b>UR Denial Date:</b>	06/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/15/2015

### 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, Indiana, Oregon  
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 50 year old male sustained an industrial injury on 2/7/15. He subsequently reported neck, back, bilateral upper and lower extremities. Diagnoses include left shoulder impingement syndrome and acromioclavicular joint arthrosis. Treatments to date include x-ray testing and prescription pain medications. The injured worker continues to experience neck pain that radiates to the bilateral shoulders, back pain that radiates to the bilateral lower extremities and bilateral knee pain. Upon examination, there was tenderness and spasm of cervical paraspinal muscles. Range of motion was reduced. A request for Post-operative polar care unit x 2 weeks rental, home use, Range of motion testing for the cervical spine and Post-op physical therapy x 12 for the left shoulder was made by the treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative polar care unit x 2 weeks rental, home use:** 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.

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

**Decision rationale:** 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. CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately post-operatively for up to 7 days. In this case the requested duration exceeds the guideline recommendations and the request is therefore not medically necessary.

**Range of motion testing for the cervical spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

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

**Decision rationale:** CA MTUS/ACOEM is silent on separate range of motion testing of the neck. According to OGG neck section, flexibility, there is no correlation of range of motion differences and functional impairment. Based on this, the request to assess the range of motion beyond the initial clinical examination recommended in the ACOEM guidelines, is not medically necessary.

**Post-op physical therapy x 12 for the left shoulder:** Overturned

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

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

**Decision rationale:** 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. Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of post-surgical 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. 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 it is indicated that a subacromial decompression has been authorized. In that case, the recommended number of visits has been requested and is therefore medically necessary.