

<b>Case Number:</b>	CM15-0032890		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	09/04/2014
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	01/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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, 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 55 year old male, who sustained an industrial injury on 09/04/2014. The injured worker was diagnosed as having shoulder sprain; shoulder impingement syndrome; superior glenoid labrum lesion. Treatment to date has included physical therapy x6; right shoulder MRI (12/17/14). Currently, according to the PR-2 note dated 01/16/2015, the injured worker reported right shoulder pain. The physical examination of the right shoulder revealed positive impingement sign, positive Hawkins test, tenderness over the greater tuberosity, forward elevation to 160 degrees, and abduction to 130 degrees. An x-ray of the right shoulder revealed AC joint arthrosis. The treatment plan for a right shoulder arthroscopy debridement, SAD, RCR with possible bicep tenotomy vs tenodesis labral tear and a DME sling have been authorized. The provider has also requested: Cold therapy unit which was modified to 7 days; a Continuous Passive Motion (CPM) machine was denied as not medically necessary; post-operative physical therapy 3x8 was modified to authorize 6 sessions postoperatively only and ; medical clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: 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).

**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:** California MTUS Guidelines state continuous flow cryotherapy is recommended following surgery for up to 7 days. In this case, the injured worker has been issued authorization for a right shoulder arthroscopy. However, the request for a cold therapy unit purchase would not fall within guideline recommendations. Therefore, the request is not medically necessary.

**Associated surgical service: Continuous Passive Motion (CPM) Machine:** 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).

**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 Passive Motion.

**Decision rationale:** According to the Official Disability Guidelines, continuous passive motion is not recommended for shoulder rotator cuff problems. It has been recommended as an option for adhesive capsulitis. The injured worker does not maintain a diagnosis of adhesive capsulitis. The injured worker has been issued authorization for a right shoulder arthroscopy with subacromial decompression and rotator cuff repair. The injured worker does not meet criteria for the requested durable medical equipment. As such, the request is not medically necessary at this time.

**Post-operative Physical Therapy 3 x 8:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 26-27.

**Decision rationale:** California MTUS Guidelines state the initial course of therapy means 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. In this case, the injured worker has been issued authorization for a right shoulder arthroscopy with subacromial decompression and rotator cuff repair. Postsurgical treatment includes 24 sessions over 14 weeks. The California MTUS Guidelines would support an initial course of therapy means 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 of 12 sessions of physical therapy. The current request for an initial 24 sessions would exceed guideline recommendations. In

addition, the request as submitted failed to indicate the specific body part to be treated. As such, the request is not medically necessary.

**Associated surgical service: Medical Clearance: 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) Low Back Chapter, Preoperative testing, general.

**Decision rationale:** The Official Disability Guidelines state the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, there is no documentation of a significant medical history or any underlying comorbidities to support the necessity for preoperative medical clearance. As the medical necessity has not been established, the request is not medically appropriate at this time.