

Case Number:	CM13-0045987		
Date Assigned:	12/27/2013	Date of Injury:	04/21/2013
Decision Date:	05/28/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/12/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is an [REDACTED] employee who has filed a claim for right shoulder pain associated with an industrial injury date of April 21, 2013. Thus far, the patient has been treated with right shoulder arthroscopy decompression surgery performed October 02, 2013, physical therapy, cortisone injection, medications, and work restrictions. In a utilization review report of October 31, 2013, the claims administrator denied a request for Albuterol pro inhaler as there was no documentation of the patient's respiratory condition, physical therapy 3x6 for the right shoulder as the number of post-op physical therapy sessions to date was unknown with no documentation regarding significant improvement from previous sessions, and x-ray of the right shoulder as there was no documentation of significant right shoulder complaints or objective findings that would necessitate an x-ray evaluation. Review of progress notes shows that post-operatively, patient had residual limitations of the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARBUTEROL PRO AIR INHALER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/albuterol.html>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary Chapter, Albuterol (Ventolin); Asthma Medications.

Decision rationale: CA MTUS does not apply. As noted in ODG, Albuterol is the recommended inhaled short-acting beta-2-agonists as a first-line choice for asthma. In this case, there is no documentation that the patient has asthma or respiratory symptoms that would necessitate the inhaler. Therefore, the request for Albuterol pro air inhaler was is not medically necessary and appropriate

PHYSICAL THERAPY 3 X WK X 6 WKS RIGHT SHOULDER: Upheld

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

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

Decision rationale: As noted on page 114 of the MTUS ACOEM Guidelines, and pages 98-99 of the Chronic Pain Medical Treatment Guidelines, there is support for an initial course of physical therapy with objective functional deficits and functional goals. ODG recommends 24 visits over 14 weeks for post-arthroscopic cases. In this case, patient has had 12 sessions of physical therapy prior to the shoulder surgery. There is no documentation regarding post-op PT sessions; however, there is also no documentation regarding specific objective and functional deficits in this patient that would necessitate physical therapy sessions. Therefore, the request for physical therapy 3x6 to the right shoulder was is not medically necessary and appropriate.

X-RAY RIGHT SHOULDER: 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): 55-559. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Radiography.

Decision rationale: CA MTUS criteria for imaging include emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; or clarification of the anatomy prior to an invasive procedure. In addition, as noted in (ODG) Official Disability Guidelines, plain radiographs should be routinely ordered for patients with chronic shoulder pain. The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. However, ultrasonography may emerge as a cost-effective alternative to MRI. In this case, there is no documentation regarding significant pain post-operatively to support necessity for additional radiographic imaging of the right shoulder. The rationale for ordering an x-ray was not specified. Therefore, the request for x-ray of the right shoulder was is not medically necessary and appropriate.