

Case Number:	CM14-0102905		
Date Assigned:	07/30/2014	Date of Injury:	10/23/2012
Decision Date:	08/29/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	07/03/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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:

This case involves a 55 year old female who sustained an injury on 10/23/12. Based on the clinical reports submitted, it appears that the injured worker has multiple dates of injury due to repetitive activities. There was a noted recent fall in March of 2013. The injured worker has been followed for multiple complaints to include left shoulder pain. Prior imaging studies did note degenerative joint changes in the left shoulder with narrowing of the subacromial space. The injured worker had been previously treated with physical therapy as well as medications however, has continuing complaints of left shoulder pain despite conservative treatment. The clinical report from 06/10/14 indicated the injured worker had persistent left anterior shoulder pain with pain over the acromioclavicular joint. There was limited range of motion in the left shoulder as compared to the right with positive impingement signs. There was a recommendation for surgical intervention for this injured worker to include subacromial decompression and distal clavicle resection. It is noted that these procedures were approved by utilization review on 06/06/14. The accompanying request to include preoperative medical clearance with labs, electrocardiogram and chest x-ray as well as a micro cool rental or purchase, transcutaneous electrical nerve stimulation unit and supply rental or purchase, continuous passive motion rental or purchase, and Flexeril 10mg, quantity 90 with 3 refills, which were denied by utilization review on 06/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-op medical clearance/labs/EKG/Chest x-ray: 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) Low Back Chapter, Pre-operative testing, General.

Decision rationale: In regards to the request for preoperative medical clearance with laboratory studies, electrocardiogram and chest x-rays, this reviewer would not have recommended this request as medically necessary. It is noted that this request was modified by the 06/06/14 report for laboratory studies only. Given the lack of any significant comorbid issues in the clinical documentation, preoperative laboratories would be sufficient to rule out risk factors for operative intervention and anesthesia. Therefore, this request is not medically necessary.

Micro cool (rental or purchase): 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 Cold Therapy System.

Decision rationale: In regards to the request for a micro cool system rental or purchase, this reviewer would not have recommended this request as submitted as medically necessary. It is noted in the prior utilization report from 06/06/14 that the request was modified to a rental period of 7 days only. This would be consistent with guideline recommendations therefore, the request is not medically necessary.

Tens unit and supplies (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 113-117.

Decision rationale: In regards to the request for a transcutaneous electrical nerve stimulation (TENS) unit and supplies rental or purchase, the request is not medically necessary. This decision was based on review of the clinical documentation submitted as well as current evidence based guidelines. The request is non-specific in regards to a rental with a time period or purchase. Guidelines do not recommend the use of a TENS unit for the shoulder outside of rehabilitation following stroke injuries. In this case, there is no support for postoperative use of a TENS unit for the left shoulder per guidelines. Therefore, this request is not medically necessary.

CPM Machine/kit (rental or purchase): 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: In regards to the request for a continuous passive motion (CPM) unit for the left shoulder postoperatively, this request is not medically necessary. Per guidelines, continuous passive motion devices are not recommended for the shoulder with the exception of treatment of adhesive capsulitis. The requested and approved surgical procedures for the left shoulder would not support the use of a postoperative CPM unit. Also, the request is non-specific in regards to a rental with a time period or a purchase. Therefore, the request is not medically necessary.

Flexeril 10mg #90 (refill times three): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67.

Decision rationale: In regards to the use of Flexeril 10mg quantity 90, this request is not medically necessary. This decision was based on the clinical documentation provided for review and current evidence based guideline recommendations. The chronic use of muscle relaxers is not recommended by current evidence based guidelines. At most, muscle relaxers are recommended for short term use only. The efficacy of chronic muscle relaxer use is not established in the clinical literature. There is no indication from the clinical reports that there had been any recent exacerbation of chronic pain or any evidence of a recent acute injury. Therefore, this reviewer would not recommend ongoing use of this medication at this time.