

Case Number:	CM14-0011997		
Date Assigned:	02/21/2014	Date of Injury:	08/03/2011
Decision Date:	06/27/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	01/30/2014

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 Orthopedic Surgery, 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:

This is a 52-year-old female with an 8/3/11 date of injury. She is a female [REDACTED] for the [REDACTED] and injured both shoulders. A supplemental note on 12/13/13 indicates the patient "has had good results with therapy" and chiropractic care and adjunctive PT was recommended. On 12/20/13, the patient presented with weakness and pain in her right shoulder. Objective: 135 to 150 degrees of abduction and 145 of forward flexion. Diagnostic Impression: bilateral shoulder impingement syndrome, partial thickness supraspinatus tears of bilateral shoulders, right shoulder calcific tendinitis. Treatment to date: right shoulder subacromial decompression and Mumford procedure 9/4/13, medication management, post-operative physical therapy. A UR decision dated 1/21/14 denied the request for a P-stim purchase or rental based on the fact that there is no documentation of why the device is being requested. Physical therapy was denied because it is unclear whether this request is for physical therapy or chiropractic care. Acupuncture was denied because there is a lack of information as to a basis for alternative forms of pain management.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE TWO TIMES SIX RIGHT SHOULDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS does not consistently and overwhelmingly support the use of acupuncture in the management of shoulder injuries. However, ODG states that among those shoulder indications found to have positive outcomes from acupuncture were rotator cuff tendonitis, frozen shoulder, subacromial impingement syndrome, and rehab following arthroscopic acromioplasty. Additionally, ODG supports an initial trial of 3 to 6 visits. This patient is s/p right shoulder subacromial decompression and Mumford procedure 9/4/13 and guidelines do support an initial trial of acupuncture of 3 to 6 visits. However, this request is for 12 sessions of acupuncture, which guidelines do not support. Guidelines only support additional acupuncture if there is documentation of functional improvement after the initial acupuncture trial. The recommendation would be for an initial trial of 6 sessions of acupuncture to establish efficacy. However, this request cannot be modified for the purpose of this review. This request, as submitted, is not medically necessary.

PHYSICAL THERAPY TWO TIMES SIX RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: CA MTUS Post-Surgical Treatment Guidelines support up to 24 sessions of physical therapy over a 14 week period. The post-surgical treatment period is 6 months. However, for continued physical therapy, there should be documentation of functional improvement and gains from previous physical therapy. In addition, there is no clear documentation of the number of sessions of physical therapy the patient has had since the surgery. In order for additional physical therapy to be considered medically necessary, it is important to take into account the number of sessions previously attended. This request, as submitted, is not medically necessary.

P-STIM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 2009: TENS Page(s): 114-116.

Decision rationale: CA MTUS states that TENS is recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. CA MTUS Chronic Pain Medical Treatment Guidelines state that TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. Criteria for the use of TENS unit include Chronic intractable pain - pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication)

and failed, and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit. However, the patient is not within the first 30 days post-operatively. There is no clear discussion of why the electrical stimulator unit is being requested. There is no documentation of failure of conservative management. This request, as submitted, is not medically necessary.