

Case Number:	CM14-0024746		
Date Assigned:	06/11/2014	Date of Injury:	04/21/2013
Decision Date:	07/15/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/26/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Minnesota. 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 injured worker is a 31-year-old female who reported an injury on 04/21/2013. The mechanism of injury was not provided in the documentation. Per the progress note dated 01/21/2014, the injured worker reported continued stiffness to the right shoulder. On examination, the strength of the right shoulder was 4+, abduction was 160 degrees, flexion was 165 degrees, internal rotation was 60 degrees, and external rotation was 40 degrees. The documentation stated the injured worker had undergone right shoulder arthroscopic surgery on 10/02/2013. An electromyography (EMG) performed prior to the surgery noted mild, right-sided S1 radiculopathy, normal right upper extremity, and normal left-sided EMG. There was no radiculopathy noted on the left side. Previous treatments for the injured worker included acupuncture, physical therapy, surgery, and imaging studies. The Request for Authorization for medical treatment dated 01/22/2014 included acupuncture, physical therapy, and a shoulder exercise kit purchase. However, the provider's rationale for the request was not provided in the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE TWO (2) TIMES A WEEK TIMES SIX (6) WEEKS TO RIGHT SHOULDER / LUMBAR SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture 2 times a week times for 6 weeks to the right shoulder and lumbar spine is not medically necessary or appropriate. Per the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain and inflammation, increase blood flow and range of motion, decrease side effects of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Time to produce functional improvement is 3 to 6 treatments with a frequency of 1 to 3 times per week and an optimum duration of 1 to 2 months. However, acupuncture treatments may be extended if functional improvement is documented. The documentation provided indicates the injured worker had 9 acupuncture visits over a 6-week period prior to her surgery; however, the areas treated and the efficacy of those treatments is not provided. There is a lack of documentation regarding any acupuncture treatments provided after the surgery and the efficacy of those treatments. There is a lack of documentation regarding deficits related to the lumbar spine to warrant treatment with acupuncture. There is a lack of documentation regarding the injured worker's reduced pain medication or intolerance of pain medication to warrant acupuncture. In addition, the guidelines recommend 3 to 6 treatments to produce functional improvement; however, the request is for 12 treatments. Therefore, the request for acupuncture 2 times a week for 6 weeks to the right shoulder and lumbar spine is not medically necessary or appropriate.

PHYSICAL THERAPY ONE (1) TIME A WEEK FOR SIX (6) WEEKS TO THE RIGHT SHOULDER / LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter (Lumbar & Thoracic), Physical Therapy Guidelines, and Preface, Physical Therapy Guidelines.

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

Decision rationale: The request for physical therapy (PT) 1 time a week for 6 weeks to the right shoulder and lumbar spine is not medically necessary or appropriate. Per the California MTUS Chronic Pain guidelines, active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion and can alleviate discomfort. Active therapy requires an internal effort from the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend 8 to 10 visits over 4 weeks. In addition, they allow for the fading of treatment frequency from up to 3 visits a week to 1 or less, plus active self-directed home physical medicine. The documentation dated 10/20/2014 instructed the injured worker to continue physical therapy under the treatment plan; however, there is a lack of clinical documentation regarding the efficacy of the postsurgical physical therapy treatments.

There is a lack of documentation regarding a home-based exercise program and the injured worker's compliance with that program. There is a lack of documentation regarding any shoulder deficits that cannot be addressed with a home-based exercise program. Therefore, the request for physical therapy 1 time a week for 6 weeks to the right shoulder/lumbar spine is not medically necessary or appropriate.

SHOULDER EXERCISE KIT-PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Home Exercise Kits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Home Exercise Kits.

Decision rationale: The request for a shoulder exercise kit purchase is not medically necessary or appropriate. Per Official Disability Guidelines, home exercise kits are recommended where home exercise programs and active, self-directed, home physical therapy is recommended. Self-training may be as effective as therapist-supervised rehabilitation of the shoulder in postsurgical treatment of patients treated with arthroscopic subacromial decompression. There is a lack of documentation regarding a home-based exercise program for the injured worker and the injured worker's compliance with that program. In addition, there is a lack of documentation within the request regarding the components of the requested kit. Therefore, the request for shoulder exercise kit purchase is not medically necessary or appropriate.