

Case Number:	CM14-0056595		
Date Assigned:	07/09/2014	Date of Injury:	06/09/2011
Decision Date:	08/08/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/25/2014

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 Colorado and 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:

The injured worker is a 48-year-old female who reported an injury on 08/11/2012 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her neck and right shoulder and bilateral wrists. The injured worker was conservatively treated, had continued pain complaints, and activity limitations of the right shoulder. The injured worker was evaluated on 03/04/2014. Physical findings included restricted range of motion secondary to pain with tenderness to palpation of the cervical spine, restricted range of motion of the right shoulder with tenderness to palpation over the acromioclavicular joint and upper volar region musculature with 4/5 strength in flexion. The injured worker's diagnoses included mild ligamentous cervical spine sprain/strain, rotator cuff tear right shoulder, impingement of the right shoulder, status post right carpal tunnel release, and status post left carpal tunnel release. The injured worker's treatment plan included surgical intervention to include subacromial decompression, rotator cuff repair and excision of the distal clavicle. The injured worker was again evaluated on 04/01/2014. It was noted that a request for surgical intervention was authorized.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post op Physical Therapy two times a week for twelve weeks 2x12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: California Medical Treatment Utilization Schedule recommends up to 24 visits of physical therapy in the post surgical management of a rotator cuff repair. However, California Medical Treatment Utilization Schedule also recommends an initial course of treatment equal to half the number of recommended visits. This would be 12 physical therapy visits. The request exceeds this recommendation. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested postoperative physical therapy 2 times a week for 12 weeks is not medically necessary or appropriate.

DME/ARC 2.0 abduction pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Postoperative abduction pillow sling.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Postoperative abduction pillow sling.

Decision rationale: The American College of Occupational and Environmental Medicine does recommend a short period of immobilization for acute pain of a shoulder injury. The clinical documentation does indicate that the injured worker will undergo surgical intervention which would result in acute pain that would benefit from a short period of immobilization. However, Official Disability Guidelines recommend a sling with an arm abduction pillow for patients who undergo massive open rotator cuff repair. This type of intervention is not supported for arthroscopic surgical interventions. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested DME/ARC 2.0 abduction pillow is not medically necessary or appropriate.

Cold compression unit for 2 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter, Continuous Flow Cryotherapy.

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 Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines recommend a continuous flow cryotherapy unit for up to 7 days in the postsurgical management of a shoulder injury. The request exceeds

this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested cold compression unit for 2 weeks is not medically necessary or appropriate.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Use of Opioids: Urine Drug Screen. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Chapter, Urine drug testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing, page(s) 43 Page(s): 43.

Decision rationale: California Medical Treatment Utilization Schedule recommends urine drug screening for patients who exhibit signs and symptoms of illicit drug use or to assess for aberrant behavior for patients that use opioids to manage chronic pain. The clinical documentation submitted for review did not provide any indication of medications that would require a urine drug screen. The clinical documentation submitted for review does not provide any evidence that the injured worker has any risk factors for illicit drug use and would require urine drug screen. As such, the requested urine drug screen is not medically necessary or appropriate.