

Case Number:	CM14-0089717		
Date Assigned:	09/08/2014	Date of Injury:	10/26/2013
Decision Date:	10/14/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/13/2014

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 Anesthesiology, has a subspecialty in Pain Medicine, 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 injured worker is a 45 year old female who sustained an injury on 10/26/13 when she slipped and fell injuring her left shoulder. The injured worker was found to have a partial tear of the middle glenohumeral ligament in the left shoulder on MRI from 01/30/14. The injured worker had not improved with prior conservative treatment including physical therapy. Physical examination from 05/27/14 noted muscle spasms in the paracervical musculature with intact strength. There were positive impingement signs at the left shoulder with no tenderness over biceps tendon. There was tenderness over the acromioclavicular joint with positive crossover sign. No weakness was identified. There was no substantial loss of range of motion in the left shoulder. The injured worker was recommended for left shoulder arthroscopy including subacromial decompression and resection of acromioclavicular joint. This procedure was certified by utilization review on 06/04/14. The requested post-operative physical therapy for 18 sessions for the neck back and left shoulder and diclofenac omeprazole and vascutherm DVT cold compression unit for 21 days was denied by utilization review on 06/04/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST-OP PT 3X6 FOR NECK, BACK AND LEFT SHOULDER: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: In review of the clinical documentation submitted for review the injured worker was recommended for a left shoulder arthroscopy which was certified by review on 06/05/14. It is noted in the utilization review that physical therapy was modified to one to two visits per week per eight weeks for a total of 16 sessions. Per post-operative therapy guidelines for the requested procedure the recommendation is for 24 post-operative physical therapy sessions over 14 weeks period. The requested 18 sessions of physical therapy were well within these guideline recommendations for the shoulder. Given the multiple procedures requested for the shoulder and the recommendations from post-operative guidelines this reviewer would have recommended this request as medically necessary. Therefore the request is medically necessary and appropriate.

DICLOFENAC: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI INFLAMMATORY MEDICATIONS Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: Diclofenac was requested for post-operative treatment of inflammation and pain. Guidelines would recommend diclofenac for post-operative use to address swelling and pain. Prior utilization review from 06/05/14 modified this request to a quantity of 60 for 30 day duration. Given the submitted request was non-specific for dose frequency efficacy dose frequency quantity or duration this reviewer would not have recommended the request as submitted as medically necessary. Therefore the request is not medically necessary.

OMEPRAZOLE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, proton pump inhibitors

Decision rationale: The requested omeprazole was for GI protection from use of diclofenac. There is a higher risk for GI complications with anti-inflammatories as noted by current evidence based guidelines. The prior utilization review from 06/05/14 modified the request for quantity of 30 for 30 day duration. Given that the submitted request was not specific in terms of dose frequency quantity or duration this reviewer would not have recommended this request as submitted as medically necessary. Therefore the request is not medically necessary.

VASCUTHERM 4 WITH DVT COLD COMPRESSION X 21 DAYS: 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, 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, Cryotherapy

Decision rationale: This reviewer would not have recommended this request for vasotherm 4 with DVT cold compression times 21 days as medically necessary. Per guidelines the use of vasotherm cold compression systems for the shoulder can be utilized in a perioperative. Up to seven days only. The requested 21 days would be considered excessive for the procedures requested. Prior utilization review noted the request was modified to seven day rental. This would be consistent with guideline recommendations. Therefore the request is not medically necessary and appropriate.