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| Case Number: | CM14-0195903 | | |
| Date Assigned: | 12/03/2014 | Date of Injury: | 04/06/2012 |
| Decision Date: | 01/30/2015 | UR Denial Date: | 11/13/2014 |
| Priority: | Standard | Application Received: | 11/21/2014 |

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 Georgia. 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 39-year-old male who reported an injury on 04/06/2012. The mechanism of injury was a fall. His diagnoses were noted to include left shoulder impingement syndrome with biceps tendonitis, right shoulder impingement syndrome and biceps tendonitis, depression secondary to pain, right hip pain/greater trochanteric bursitis, low back pain, and bilateral knee patellofemoral pain syndrome. Past treatment was noted to include injections, surgery, acupuncture therapy, and medications. The clinical documentation submitted for review suggested he had right shoulder surgery; however, it was not indicated what surgery he had or when. On 09/23/2014, it was noted the injured worker had pain to his left shoulder which he rated 8/10 and his pain to his right shoulder "improved with the current care." Upon physical examination, it was noted the injured worker's right shoulder had well healed scars and tenderness over the anterior glenohumeral joint. It was indicated the injured worker had positive Neer's, Hawkins, and Speed's tests. It is noted the injured worker's motor strength on abduction and external rotation measured 4/5. It was noted he had slightly decreased range of motion measuring flexion at 170 degrees, internal rotation measured 60 degrees, and external rotation measured 80 degrees bilaterally. His relevant medications include diclofenac 100 mg and Omeprazole 20 mg. His treatment plan was noted to include an injection to the left shoulder, physical therapy, massage therapy, and acupuncture as well as refill of medication. A request was received for Associated surgical service: Postop: Home Care (8 Hours/Day times 6 Days/Week) (Weeks) QTY: 2.00; Associated surgical service: Postop: Vascutherm 4 with DVT, Cold Compression (Rental) QTY: 21.00; and Associated surgical service: Continue Acupuncture QTY: 18.00. The Request for Authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: postop: home care (8 hours/day times 6 days/week) (weeks)
Qty: 2.00:** Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: The request for Associated surgical service: Postop: Home Care (8 Hours/Day times 6 Days/Week) (Weeks) Qty: 2.00 is not medically necessary. According to the California MTUS Guidelines, home health services are recommended for those who are home bound for no more than 35 hours a week. The clinical documentation submitted for review did not note if this injured worker was home bound. Additionally, the request exceeds the guideline recommended duration of treatment. In the absence of documentation noting this injured worker is home bound and as the request exceeds the guideline recommended duration of treatment, the request is not supported by the evidence based guidelines. As such, the request for Associated surgical service: postop: home care (8 hours/day times 6 days/week) (weeks) Qty: 2.00 is not medically necessary.

**Associated surgical service: Postop: Vascutherm 4 with DVT, Cold Compression (Rental)
Qty: 21.00:** Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The American College of Occupational and Environmental Medicine (ACOEM) Occupational Medicine Practice Guidelines, APG I Plus, 2009; Official Disability Guidelines (ODG); Integrated Treatment/Disability Duration Guidelines, Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous-flow cryotherapy and Official Disability Guidelines (ODG) Knee & Leg, Game Readyâ accelerated recovery system.

Decision rationale: The request for Associated surgical service: Postop: Vascutherm 4 with DVT, Cold Compression (Rental) Qty: 21.00 is not medically necessary. According to the Official Disability Guidelines, cryotherapy is recommended after a surgical procedure and may be used up to 7 days postoperatively. It has been proven to decrease pain, inflammation, swelling, and narcotic usage. The clinical documentation submitted for review did not note that the injured worker had pain, inflammation, swelling, or narcotic usage. Additionally, the request is for a quantity of 21 and the guidelines recommend no more than 7 days. Consequently, the request is not supported by the evidence based guidelines. As such, the request for Associated surgical service: Postop: Vascutherm 4 with DVT, Cold Compression (Rental) Qty: 21.00 is not medically necessary.

Associated surgical service: Continue Acupuncture Qty: 18.00: 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 Associated surgical service: Continue Acupuncture Qty: 18.00 is not medically necessary. According to the California MTUS Guidelines, acupuncture is an option when pain medication is reduced or not tolerated. It is used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication induced nausea, promote relaxation, and reduce muscle spasm. The clinical documentation submitted for review did not note how his previous chiropractic therapy benefited him or if pain medication was reduced or not tolerated. Furthermore, the documentation submitted for review did not note the injured worker had pain, inflammation, decreased blood flow, decreased range of motion, or increased side effects of medication to warrant the medical necessity for this request. Additionally, the request does not specify which body region this is to benefit. In the absence of documentation noting how the previous acupuncture therapy visits have benefited him and as there is no rationale to warrant the medical necessity of this request, the request is supported by the evidence based guidelines. As such, the request for associated surgical service: Continue Acupuncture Qty: 18.00 is not medically necessary.