

Case Number:	CM15-0130003		
Date Assigned:	07/16/2015	Date of Injury:	07/19/2011
Decision Date:	09/18/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/06/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 55-year-old female, who sustained an industrial injury on July 19, 2011. She reported bilateral shoulder pain with right thumb and wrist pain. The injured worker was diagnosed as having left shoulder sprain/strain with impingement and SLAP tear, AC joint osteophyte and right wrist tendinosis status post-surgical intervention. Treatment to date has included diagnostic studies, surgical intervention, and right wrist and thumb splint and work restrictions. Currently, the injured worker complains of continued pain as noted with associated sleep difficulties. The injured worker reported an industrial injury in 2011, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on May 14, 2015, revealed continued pain. It was noted she had a healed surgical scar on the right wrist. She was prescribed a right wrist and thumb splint for support during work. Evaluation on June 30, 2015, revealed a positive Finklestein's test. Joint pain, muscle spasms and difficulty sleeping were noted. The rest of the reports were hand written and difficult to decipher. Continuous cold therapy unit; purchase, left shoulder ultrasound and Ultracin topical lotion 120ml apply BID were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Ultrasound: 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, Ultrasound, diagnostic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder section, ultrasound, diagnostic.

Decision rationale: CA MTUS/ACOEM is silent on the issue of diagnostic ultrasound on the shoulder. According to ODG, Shoulder section, ultrasound, diagnostic, it is recommended for detection of full thickness rotator cuff tears. In this case, the submitted clinical notes demonstrate no evidence clinical to suspect a full thickness rotator cuff tear. CA MTUS/ACOEM is silent on the issue of therapeutic ultrasound on the shoulder. According to ODG, Shoulder section, ultrasound, diagnostic, it is recommended for detection of full thickness rotator cuff tears. In this case, the submitted clinical notes demonstrate no evidence clinical to suspect a full thickness rotator cuff tear. Recommended as indicated below. The evidence on therapeutic ultrasound for shoulder problems is mixed. Ultrasound provided clinically important pain relief relative to controls for patients with calcific tendonitis of the shoulder in the short term. However, the evidence does not support use of ultrasound for other conditions of the shoulder. There is no evidence of the effect of ultrasound in generalized shoulder pain (mixed diagnosis), adhesive capsulitis or rotator cuff tendinitis. In this case, the exam note from 6/30/15 does not demonstrate evidence of calcific tendonitis. The use of therapeutic ultrasound for the requested injection is therefore not medically necessary.

Continuous cold therapy unit; purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, and Hand Chapter, Online Version, Cold Packs.

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: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case, there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore, the determination is for not medically necessary.

Ultracin topical lotion 120ml apply BID: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: Ultracin is composed of menthol, methyl salicylate and capsaicin. According to ODG, capsaicin is indicated only if: "Recommended only as an option in patients who have not responded or are intolerant to other treatments." In this case, there is no evidence

that the patient is intolerant of other treatments and thus the recommendation is for not medically necessary.