

Case Number:	CM15-0180497		
Date Assigned:	09/28/2015	Date of Injury:	09/23/2011
Decision Date:	12/08/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	09/14/2015

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: Minnesota, Florida 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 female, with a reported date of injury of 09-23-2011. The injured worker's date of birth was not indicated in the medical records provided. The diagnoses include right shoulder AC (acromioclavicular) arthrosis, right shoulder anterior labral tear, and status post right shoulder arthroscopy with labral debridement, subacromial decompression. Treatments and evaluation to date have included right shoulder surgery. The diagnostic studies to date have not been included in the medical records. The medical report dated 07-28-2015 indicates that the injured worker had a right shoulder arthroscopy, but continued to have moderate to severe right shoulder pain. The physical examination of the right shoulder showed tenderness over the greater tuberosity, positive Neer's test, positive AC joint tenderness, positive AC joint compression, positive crossover test, intact neurovascular status, normal muscle testing, tenderness and spasm in the parascapular musculature, abduction at 170 degrees, forward flexion at 170 degrees, internal rotation at 60 degrees, and external rotation at 80 degrees. The treatment plan included a right shoulder arthroscopy, subacromial decompression, and AC joint resection with debridement of the anterior labral tear; post-operative physical therapy 2-3 times per week for 6 weeks; ice therapy unit; a TENS unit trial; postoperative medication: Diclofenac XR for anti-inflammation; and post-operative medication: Omeprazole for prophylaxis for chronic non-steroidal anti-inflammatory drug use. It was noted that the injured worker had work restrictions, and if the work restrictions were unable to be accommodated, the injured worker would be considered temporarily totally disabled. The request for authorization was dated 07-28-2015. The treating physician requested post-operative TENS unit for 30-day trial, post-operative ice therapy unit for a 30-day rental, post-operative

physical therapy for the right shoulder three times a week for six weeks, post-operative medication: Diclofenac XL 100mg #30, and post-operative medication: Omeprazole 20mg #30. On 08-10-2015, Utilization Review (UR) non-certified the request for post-operative TENS unit for 30-day trial, post-operative ice therapy unit for a 30-day rental, post-operative physical therapy for the right shoulder three times a week for six weeks, post-operative medication: Diclofenac XL 100mg #30, and post-operative medication: Omeprazole 20mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post op TENS unit for 30 day trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The injured worker is a 54-year-old female with a date of injury of 9/23/2011. She underwent right shoulder arthroscopy with labral debridement and subacromial decompression on 7/3/2012. Per orthopedic evaluation of 7/28/2015 she complained of moderate to severe right shoulder pain. On examination she was tender over the greater tuberosity and the acromioclavicular joint. Arthroscopy scars were well healed. Impingement testing was positive. Acromioclavicular joint compression and crossover test were positive. An MRI scan of the right shoulder dated 6/7/2013 unofficially revealed mild degenerative changes of the acromioclavicular joint, no rotator cuff tear, and thin linear signal within the anterosuperior and anterior labrum. On 8/10/2015 utilization review noncertified a request for TENS unit 30 day trial, ice therapy unit 30 day rental for the right shoulder. Additional requests for postoperative physical therapy 18 and post-operative medications diclofenac XR 100 mg #30 and omeprazole 20 mg #30 were also noncertified. The reason for non-certification was that the requested surgery had been non-certified. With regard to the request for a postoperative TENS unit for 30 day trial, California MTUS chronic pain guidelines recommend the TENS unit as a treatment option for acute postoperative pain in the first 30 days after surgery particularly for thoracotomy pain. It has been shown to be of lesser effect or not at all for other orthopedic surgical procedures. The injured worker is not having any surgery per available records. As such, the request for the TENS unit is not supported and the medical necessity of the request has not been substantiated.

Post op Ice therapy unit for 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter (updated 07/30/2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

Decision rationale: ODG guidelines recommend continuous flow cryotherapy as an option for postoperative use after shoulder surgery for 7 days. The documentation submitted indicates that the surgical procedure has not been certified. As such, the request for the ice therapy unit for 30 day rental is not supported and the medical necessity of the request has not been substantiated.

Post-op physical therapy x18, 3 times a week for 6 weeks, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter: Physical therapy guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

Decision rationale: California MTUS post-surgical treatment guidelines recommend 24 visits over 14 weeks for rotator cuff syndrome/impingement syndrome. The initial course of therapy is one half of these visits which is 12. Then with documentation of continuing functional improvement a subsequent course of therapy of 12 visits may be prescribed. The request as stated is for 18 visits which exceeds the guideline recommendations and as such the medical necessity of the request has not been substantiated.

Post-op medications: Diclofenac XR 100mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: With regard to post-operative use of diclofenac XR 100 mg #30 and omeprazole 20 mg, the requested surgery is not medically necessary and therefore the postoperative medications are also not necessary. California MTUS chronic pain medical treatment guidelines do not recommend long-term use of non-steroidal anti-inflammatory drugs. The guidelines indicate that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain and in particular for those with gastrointestinal, cardiovascular or renovascular risk factors. As such, the request for diclofenac is not medically necessary.

Post-op medications: Omeprazole 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The guidelines recommend proton pump inhibitors such as omeprazole for patients at intermediate risk for gastrointestinal events and no cardiovascular disease from using NSAIDs. Since the diclofenac XR 100 is not medically necessary, the request for omeprazole 20 mg is also not medically necessary.