

Case Number:	CM15-0199348		
Date Assigned:	10/14/2015	Date of Injury:	01/04/2015
Decision Date:	12/30/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	10/09/2015

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, Indiana, Oregon
 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 48 year old female who sustained an industrial injury 01-04-15. A review of the medical records reveals the injured worker is undergoing treatment for acromioclavicular sprain-strain, of the affection soft h shoulder region, disorders of bursae and tendons in the shoulder and pain in the shoulder joint. Medical records (09-15-15) reveal the injured worker reports "increasing" pain in the right shoulder which is "severe" at night. She has difficulty sleeping and there is "increased pain" with abduction and rotation. The pain is not rated. The physical exam (09-15-15) reveals restricted range of motion of the right shoulder, with exquisite tenderness over the acromioclavicular joint and the anterolateral aspect of the acromion. Flexion, abduction and internal rotation cause accentuated pain. Prior treatment includes a right shoulder corticosteroid injection, 12 sessions of physical therapy, nonsteroidal anti-inflammatory medications, muscle relaxants, and analgesic medications. The treating provider reports the plan of care as right shoulder surgery with associated services. The original utilization review (10-08-15) non-certified the requests for DVT compression pump-stockings, medical transportation to the surgical center, an interferential unit, and an exercise kit. The request for 12 acupuncture treatments was modified to 3 treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture Qty: 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: Per the MTUS Acupuncture Medical Treatment Guidelines, pages 8 and 9, frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20 (ef). The guidelines specifically report 3-6 treatments initially. As the request is for 12 visits the request is not medically necessary.

Associated surgical service: DME IFC unit: 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): Electrical stimulators (E-stim).

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, Galvanic Stimulation, page 117 and Interferential Current Stimulation, page 118, provide the following discussion regarding the forms of electrical stimulation contained in the SurgStim 4: Galvanic stimulation is not recommended by the guidelines for any indication. In addition interferential current stimulation is not recommended as an isolated intervention. Therefore the IFC unit is not recommended by the applicable guidelines and is therefore not medically necessary.

Associated surgical service: Home Exercise kit: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

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

Decision rationale: CAMTUS/ACOEM is silent on the use of home exercise kits. ODG shoulder and knee are referenced. These kits are recommended as they are a low cost way of significantly improving clinical outcomes. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. If the surgery is approved, the request for the home exercise kits is medically necessary.

Associated surgical service: DME DVT compression pump and stockings: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg 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.

Decision rationale: CA MTUS/ACOEM is silent on compression garments for DVT prophylaxis. According to ODG, Shoulder section, Compression garments, not generally recommended in the shoulder. Deep venous thrombosis and pulmonary embolism events are common complications following lower-extremity orthopedic surgery, but they are rare following upper-extremity surgery, especially shoulder arthroscopy. It is still recommended to perform a thorough preoperative workup to uncover possible risk factors for deep venous thrombosis/ pulmonary embolism despite the rare occurrence of developing a pulmonary embolism following shoulder surgery. Mechanical or chemical prophylaxis should be administered for patients with identified coagulopathic risk factors. In this case there is no evidence of risk factor for DVT in the clinical records. Therefore the request is not medically necessary.

Associated surgical service: Medical transportation to surgery center: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Department of Health Care Services Criteria Manual Chapter 12.1, Criteria For Medical Transportation and Related Services.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of transportation. According to the ODG, Knee and Leg Chapter, Transportation is recommended for patients with disabilities preventing them from self-transport. In this case the exam notes does not demonstrate evidence of functional impairment precluding self-transportation. Therefore the determination is not medically necessary.