

Case Number:	CM15-0084819		
Date Assigned:	05/07/2015	Date of Injury:	08/20/2010
Decision Date:	06/08/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	05/04/2015

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
 Certification(s)/Specialty: Emergency Medicine

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 64-year-old female who sustained an industrial injury on 08/20/10. Initial complaints and diagnoses are not available. Treatments to date include medications, physical therapy, acupuncture, H wave unit for home use, and steroid injections. Diagnostic studies are not addressed. Current complaints include increased pain and weakness in the right shoulder. Current diagnoses include adhesive capsulitis of the shoulder, lumbago, depression, other disorders of the bursae and tendons in the shoulder, and thoracic or lumbosacral neuritis or radiculitis. In a progress note dated 04/03/15 the treating provider reports the plan of care as medications including morphine and Norco, as well as follow-up with an Orthopedist, and additional physical therapy, acupuncture and steroid joint injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture x 8 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested Acupuncture x 8 sessions is not medically necessary. CA MTUS Acupuncture Guidelines recommend note that in general acupuncture "may be used as an adjunct to physical rehabilitation." The injured worker has increased pain and weakness in the right shoulder. The treating physician has documented diagnoses that include adhesive capsulitis of the shoulder, lumbago, depression, other disorders of the bursae and tendons in the shoulder, and thoracic or lumbosacral neuritis or radiculitis. The treating physician has not documented objective evidence of derived functional benefit from completed acupuncture sessions, such as improvements in activities of daily living, reduced work restrictions, or decreased reliance on medical intervention. The criteria noted above not having been met, Acupuncture x 8 sessions is not medically necessary.

Physical therapy 2 x 4, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical therapy, Sprained Shoulder; rotator cuff.

Decision rationale: The requested Physical therapy 2 x 4, right shoulder, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Shoulder Complaints, Summary of Recommendations and Evidence, page 212; and Official Disability Guidelines (ODG), Shoulder, Physical therapy, Sprained Shoulder; rotator cuff; recommend up to 10 physical therapy sessions for this condition and continued therapy with documented objective evidence of derived functional improvement. The injured worker has increased pain and weakness in the right shoulder. The treating physician has documented diagnoses that include adhesive capsulitis of the shoulder, lumbago, depression, other disorders of the bursae and tendons in the shoulder, and thoracic or lumbosacral neuritis or radiculitis. The treating physician did not document objective evidence of derived functional improvement from completed physical therapy sessions. Finally, the completed therapy sessions should have afforded sufficient time for instruction and supervision of a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical therapy 2 x 4, right shoulder is not medically necessary.

Right should injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204,213.

Decision rationale: The requested Right shoulder injection is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition,

(2004), Chapter 9, Shoulder Complaints, Steroid injections, Page 204 and 213, note "Conservative care, including cortisone injections, can be carried out for at least three to six months before considering shoulder (rotator cuff tear) surgery" and recommend this treatment for impingement syndrome if pain has not been adequately controlled by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen) after at least 3 months. The injured worker has increased pain and weakness in the right shoulder. The treating physician has documented diagnoses that include adhesive capsulitis of the shoulder, lumbago, depression, other disorders of the bursae and tendons in the shoulder, and thoracic or lumbosacral neuritis or radiculitis. The treating physician did not document physical exam evidence indicative of current impingement syndrome, nor objective evidence of improved function secondary to previous injections. The criteria noted above not having been met, Right shoulder injection is not medically necessary.