

<b>Case Number:</b>	CM15-0090923		
<b>Date Assigned:</b>	05/15/2015	<b>Date of Injury:</b>	01/04/2012
<b>Decision Date:</b>	08/07/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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: 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 42 year old male who sustained an industrial injury on 1/4/12. The injured worker was diagnosed as having rotator cuff tear, right shoulder impingement and labrum superior labrum anterior and posterior tear. Currently, 4/6/15 the injured worker was with complaints of right shoulder discomfort. Previous treatments included right shoulder corticosteroid injection, home stretching and non-steroidal anti-inflammatory drugs. Previous diagnostic studies included a magnetic resonance imaging revealing a posterior labrum tear. The injured workers pain level was noted as 7/10. Physical examination was notable for acromioclavicular joint tenderness and positive impingement sign. The plan of care was for surgical intervention.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associate Surgical Service: MRI right shoulder: 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), MRI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 207-208.

**Decision rationale:** According to the CA MTUS/ACOEM guidelines Chapter 9 Shoulder complaints regarding imaging of the shoulder, page 207-208 recommends imaging for red flag symptoms, physiologic evidence of tissue insult or neurovascular dysfunction or failure to progress in a strengthening program. In addition, imaging such as MRI would be appropriate for clarification of anatomy prior to an invasive procedure. None of the criteria has been satisfied based upon the records reviewed from 4/6/15 as surgery has already been authorized. Therefore, the request for MRI of the shoulder is not medically necessary and appropriate.

**Associate Surgical Service: TENS Unit with supplies:** 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), Shoulder Chapter, TENS Unit.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of TENS unit for the shoulder. Per the ODG, Shoulder, electrical stimulation, "Not recommended. For several physical therapy interventions and indications (eg, thermotherapy, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy." As the guidelines do not support e-stimulation for the shoulder, the request is not medically necessary.

**Associate Surgical Service: Shoulder CPM (Continuous Passive Motion):** 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), Shoulder Chapter, CPM.

**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 passive motion.

**Decision rationale:** CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis in the exam note of 4/6/15, the request is not medically necessary.

**Associate Surgical Service: Cold therapy unit:** 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), Shoulder Chapter, Continuous-Flow Cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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, the request is for an unspecified number of days. Therefore, the request is not medically necessary.

**Keflex 500mg #12:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Bibliography Stulberg DL, Penrod MA, Blatny RA. Common bacterial skin infections. Am Fam Physician. 2002 Jul 1; 66(1): 119-24.

**Decision rationale:** CA MTUS/ACOEM and ODG are silent on the issue of Keflex. An alternative guideline was utilized. According to the American Family Physician Journal, 2002 July 1; 66 (1): 119-125, titled "Common Bacterial Skin Infections"; Keflex is often the drug of choice for skin wounds and skin infections. It was found from a review of the medical record submitted of 4/6/15 of no evidence of a wound infection to warrant antibiotic prophylaxis. The request for Keflex is therefore not medically necessary and appropriate.

**Promethazine 25mg #10:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of promethazine (Phenergan). According to the ODG Chronic Pain Chapter, Anti-emetics is used to counteract opioid induced nausea for a period of less than 4 weeks. In this case, there is insufficient evidence from the records of 4/6/15 opioid induced nausea to warrant the use of Phenergan. Therefore, the request is not medically necessary.