

Case Number:	CM14-0093190		
Date Assigned:	07/25/2014	Date of Injury:	06/25/2013
Decision Date:	10/09/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	06/19/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 49-year-old female who reported an industrial injury on 6/25/2013, 15 months ago, to the right shoulder attributed to the performance of her usual and customary job duties. The patient complained of right shoulder pain and was diagnosed with a shoulder sprain/strain. The patient subsequently underwent a right shoulder arthroscopy with rotator cuff repair on 1/16/2014. Postoperatively the patient continued to complain of right shoulder pain. The objective findings on examination included tenderness to the right deltoid muscles; right shoulder with flexion 90, abduction 90, and extension 25/50. The MRI of the right shoulder dated 5/1/2014 documented evidence of type to a chromium configuration; degenerative joint disease of acromioclavicular joint with minimal impingement on the supraspinatus musculotendinous junction; minimal distal clavicle contusion, subacromial bursitis, conjoined supraspinatus and infraspinatus tendinosis with no evidence of a tear, sub scapular tendinosis with no evidence of a tear, minimal subscapularis bursitis, injury of the anterior glenoid labrum and minimum degenerative joint disease within articular cartilage of glenoid and humeral head. The diagnosis was 10 months status post right shoulder rotator cuff repair. The treatment plan included continued acupuncture 26 sessions; range of motion and muscle testing; and additional functional restoration physical therapy supervised 26 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2x6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for 2x6 additional sessions of acupuncture directed to the postoperative right shoulder was not supported with objective evidence of functional improvement with the previous sessions of acupuncture. The patient was documented to have had prior sessions of acupuncture with no real sustained benefit. There was no sustained functional improvement documented. There was only reported symptomatic relief on a temporary basis. There is no demonstrated medical necessity for 2x6 additional sessions of acupuncture. The treating physician requested acupuncture sessions to the postoperative right shoulder based on persistent chronic pain due to the reported industrial injury and muscle pain not controlled with medications and home exercises. The request is not consistent with the recommendations of the CA Medical Treatment Utilization Schedule for the continued treatment with acupuncture. The current request is for maintenance treatment. The patient is not demonstrated to be participating in a self-directed home exercise program for conditioning and strengthening. There is no demonstrated failure of conservative care or conventional care. The patient is not demonstrated to have intractable pain and is not exhausted all treatment modalities. There was no PR-2 by the acupuncturist documented any functional improvement with the provided sessions of acupuncture. Or is no documented diminished use of medication or improved range of motion. The recent clinical documentation demonstrates that the patient has made no improvement to the cited body parts with the provided conservative treatment for the diagnoses of right shoulder arthroscopy with SAD. Acupuncture is not recommended as a first line treatment and is authorized only in conjunction with a documented self-directed home exercise program. There is no documentation that the patient has failed conventional treatment. There was no rationale supporting the use of additional acupuncture directed to the neck and back. The use of acupuncture is not demonstrated to be medically necessary. There is no demonstrated medical necessity of additional acupuncture in conjunction with physical therapy/work hardening/functional restoration prescribed at the same time.

Range of motion and muscle testing: 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), TWC(treatment in workers compensation)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7 pages 137-138; Official Disability Guidelines (ODG), fitness for duty chapter-functional capacity evaluation and the General Medical Guidelines for the practice of medicine

Decision rationale: There was no rationale by the treating physician for the medical necessity of the ROM or MMT strength testing in relation to the treatment for this patient or for the diagnoses cited or for the analysis of the cited industrial injury. There are no objective findings on examination other than limited range of motion and tenderness to palpation with the diagnoses of

lumbar spine sprain/strain and bilateral knee pain. The patient has already received physical therapy. There is no objective evidence to support the medical necessity for ROM and MMT for the treatment of the patient 18 months status postdate of injury. There was no rationale to support the medical necessity of computerized range of motion and muscle testing over the standard documentation of objective findings on physical examination. There were no provided objective findings on examination and no rationale for the use of the provided analysis for strength and ROM instead of the physical examination. There was no objective evidence to support the medical necessity of the performed assessment for the effects of the industrial injury. There is no rationale to support or demonstrated medical necessity of the requested computerized range of motion to the upper extremities. The patient should be in a self-directed home exercise program for the continuation of strengthening and conditioning. The computerized muscle testing (CMT) or MMT testing is not demonstrated to be medically necessary and has not been requested by the employer. There is no objective medically based evidence provided to support the medical necessity of the requested MMT for the effects of the reported industrial injury. There is no indication that the CMT or MMT is required to establish the patient current status over the generally accepted findings on physical examination. The procedure was not requested by the employer and is not demonstrated to be medically necessary in addition to the documented objective findings on physical examination. There is no objective evidence provided to support the medical necessity of the CMT and MMT over the objective findings documented on physical examination. There was no provided report to support the testing that was not medically necessary for the treatment of the effects of the industrial injury. The use of computerized range of motion testing is not medically necessary and is not supported with objective medically based evidence to support medical necessity. There is no demonstrated medical necessity for the computerized ROM studies for the back/BLEs and neck/BUEs of the patient. The examination of the patient's lumbar spine; upper extremities; and lower extremities eliminates the medical necessity of any possible computerized range of motion testing. The documented objective physical findings and ranges of motion in the clinical report would be established as the baseline for treatment. The ROM of the lumbar spine and lower extremities can be demonstrated in the physical examination and documented as objective findings. The procedure was not requested by the employer and is not demonstrated to be medically necessary in addition to the documented objective findings on physical examination. There is no objective evidence provided to support the medical necessity of the computerized ROM studies over the objective findings documented on physical examination.

Supervised functional restoration program 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203-204, Chronic Pain Treatment Guidelines Physical Therapy/Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6 page 114; Official Disability Guidelines (ODG), Shoulder section---physical therapy; exercises

Decision rationale: There was no clinical documentation to support the medical necessity of additional PT or a supervised functional restoration/work hardening over the recommended self-directed home exercise program for the postoperative right shoulder. There is no objective evidence provided to support the medical necessity of additional physical therapy (PT) beyond the number recommended by the CA MTUS for strengthening as opposed to the recommended HEP in order to increase range of motion. The patient has completed 24 sessions of the previously authorized PT/physiotherapy and should be integrated into a self-directed home exercise program for conditioning and strengthening. The patient is nine (9) months s/p date of surgery for the shoulder whereas the California MTUS recommends postoperative rehabilitation over 12-14 weeks. The patient has received the CA MTUS recommended number of sessions of PT. The patient is documented to have received prior sessions of postoperative rehabilitation physical therapy directed to the right shoulder. There is no provided rationale to support the additional 2x6 sessions of postoperative PT other than for increased strengthening. There was no documented muscle atrophy that required more than a simple self-directed home exercise program. The patient was reported to have less than full range of motion and some weakness, however, was not established as participating in a self-directed home exercise program as recommended by evidence-based guidelines. The recommended additional strengthening could be obtained in a self-directed home exercise program. The request exceeds the number of sessions of PT recommended by the CA MTUS for the postoperative rehabilitation of the shoulder s/p arthroscopy-SAD. The patient is documented to have received prior authorization for a significant number of sessions of PT. The CA MTUS and the Official Disability Guidelines recommend up to 24 sessions over 14 weeks of postoperative care of the shoulder subsequent to arthroscopic decompression and rotator cuff repair with an arthroscopic procedure. The patient has received more than the number of sessions recommended by the CA MTUS and should be in a self-directed home exercise program for conditioning and strengthening. There are no diagnoses that could not be addressed with HEP. The request for additional physical therapy over the recommended home exercise program is supported with objective evidence to support medical necessity. The patient has obtained the number of sessions of PT recommended by the CA MTUS for the postoperative rehabilitation of the shoulder. There is no evidence that the exercise program for the shoulder could not continue with HEP. There is no demonstrated medical necessity for an additional 2x6 sessions of physical therapy in the form of a supervised functional restoration or work hardening program directed to the postoperative right shoulder.

