

Case Number:	CM15-0112025		
Date Assigned:	06/18/2015	Date of Injury:	07/08/2012
Decision Date:	07/31/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	06/10/2015

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: Physical Medicine & Rehabilitation

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 38 year old male with an industrial injury dated 07/08/2012. His diagnoses included glenohumeral instability, right shoulder and worsening right shoulder impingement and rotator cuff tendonitis. Past medical history includes left knee and wrist dislocations. Prior treatment included surgery and physical therapy (right shoulder). He presents on 03/30/2015 for follow up. He was post capsulorrhaphy about 8 months ago. He complained of ongoing pain and numbness in the shoulder. He was evaluated on 03/09/2015 with ultrasound imaging showed no obvious rotator cuff tear. He was given a subacromial injection of local anesthetic and corticosteroid with dramatic pain relief. The injured worker states he had only short term relief following his subacromial injection. There was lateral subacromial tenderness with a positive impingement test. There was no glenohumeral joint tenderness. Tests for glenohumeral instability were negative. There was mild biceps tenderness. The record dated 03/30/2015 is the most recent record available in the submitted records. The requested treatments are game ready unit times 2 week rental, knee immobilizer and post-op appointments times 4 within global period with fluoroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op appointments x 4 within global period with fluoroscopy: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208, Chronic Pain Treatment Guidelines Pain outcome and endpoints Page(s): 8-9.

Decision rationale: Based on the 03/27/15 progress report provided by treating physician, the patient presents with right shoulder pain. The patient is status post right shoulder arthroscopic subacromial decompression, right elbow lateral extensor fasciotomy and right radial decompression 07/19/13, and right shoulder arthroscopic capsulorrhaphy 07/11/14, per 03/18/15 report. Per 06/26/15 report, the patient is status post right shoulder decompression, date unspecified. The request is for Post-Op Appointments x 4 within Global Period with fluoroscopy. Patient's diagnosis 03/27/15 included right shoulder strain and right shoulder subacromial bursitis, tenosynovitis, and tendinitis, physical examination to the right shoulder on 03/27/15 revealed diffuse tenderness. Active and passive ranges of motion are guarded in abduction and external rotation. MRI of the right shoulder dated 04/21/15 states "mild rotator cuff tendinosis with chronic SLAP tear superior labrum as the morphology of superior labrum is abnormal. There is mild degenerative change of the AC joint intact inferior glenohumeral ligament labral complex mild synovitis mid rotator cuff interval with mild tendinosis intraarticular biceps normal supraspinatus outlet shown." Treatment to date included shoulder surgeries, imaging studies, physical therapy, injections and medications. Patient's medications include Norco, Tizanidine, Nabumetone, Orphenadrine Citrate, and Terocin patch. The patient is permanent and stationary, per 06/29/15 report. Treatment reports were provided from 10/06/14 - 06/29/15. Regarding follow-up visits, MTUS guidelines page 8 has the following: "The physician treating in the workers' compensation system must be aware that just because an injured worker has reached a permanent and stationary status or maximal medical improvement does not mean that they are no longer entitled to future medical care. The physician should periodically review the course of treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of pain management depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. ACOEM Practice Guidelines, 2nd Edition (2004), Shoulder Complaints Ch.9 Special Studies and Diagnostic and Treatment Considerations, pg 207- 209 states: "For most patients with shoulder problems, special studies are not needed unless a four- to six-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red-flag conditions are ruled out..." Progress report with the request, nor RFA were provided. Treater does not provide medical rationale for the request. UR letter dated 05/11/15 states the patient "was authorized for a right shoulder synovectomy, debridement, possible tenodesis and possible biceps tenotomy followed by twelve (12) sessions of post-operative physical therapy two times a week for six weeks (2 x 6)... There is no indication of the date of surgery or why fluoroscopy is requested." The patient is status post right shoulder surgery on unspecified date, per 06/26/15 report. In this case, treater does not explain why fluoroscopic evaluation of the shoulder is being requested. It appears treater intends to examine the shoulder under fluoroscope during postop appointments. MTUS page 8 states that the treater must monitor the patient's progress and make appropriate treatment recommendations. While follow up visits are supported by guidelines, there is no indication for fluoroscopic exam for post-op. Therefore, the request is not medically necessary.

Game ready unit x 2 week rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back (Acute & Chronic) Chapter under Continuous-flow Cryotherapy.

Decision rationale: Based on the 03/27/15 progress report provided by treating physician, the patient presents with right shoulder pain. The patient is status post right shoulder arthroscopic subacromial decompression, right elbow lateral extensor fasciotomy and right radial decompression 07/19/13, and right shoulder arthroscopic capsulorrhaphy 07/11/14, per 03/18/15 report. Per 06/26/15 report, the patient is status post right shoulder decompression, date unspecified. The request is for Game Ready Unit x 2 week rental. Patient's diagnosis 03/27/15 included right shoulder strain and right shoulder subacromial bursitis, tenosynovitis, and tendinitis physical examination to the right shoulder on 03/27/15 revealed diffuse tenderness. Active and passive ranges of motion are guarded in abduction and external rotation. MRI of the right shoulder dated 04/21/15 states "mild rotator cuff tendinosis with chronic SLAP tear superior labrum as the morphology of superior labrum is abnormal. There is mild degenerative change of the AC joint intact inferior glenohumeral ligament labral complex mild synovitis mid rotator cuff interval with mild tendinosis intraarticular biceps normal supraspinatus outlet shown." Treatment to date included shoulder surgeries, imaging studies, physical therapy, injections and medications. Patient's medications include Norco, Tizanidine, Nabumetone, Orphenadrine Citrate, and Terocin patch. The patient is permanent and stationary, per 06/29/15 report. Treatment reports were provided from 10/06/14 - 06/29/15. MTUS does not discuss cold compression therapy. ODG Guidelines, Neck and Upper Back (Acute & Chronic) Chapter under Continuous-flow Cryotherapy states: "Recommended as an option after shoulder surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days." Progress report with the request, or RFA were provided. Treater does not provide medical rationale for the request. ODG guidelines support continuous-flow cryotherapy as an option after shoulder surgery. UR letter dated 05/11/15 states the patient "was authorized for a right shoulder synovectomy, debridement, possible tenodesis and possible biceps tenotomy followed by twelve (12) sessions of post-operative physical therapy two times a week for six weeks (2 x 6)." In this case, the patient is status post right shoulder surgery on unspecified date, per 06/26/15 report. Given the patient's status post condition, continuous-flow cryotherapy might have been indicated. However, the request is for 14 days rental. ODG allows post-operative use for up to 7 days. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.

Knee immobilizer: 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 Knee & Leg (Acute & Chronic) Chapter under Immobilization.

Decision rationale: Based on the 03/27/15 progress report provided by treating physician, the patient presents with right shoulder pain. The patient is status post right shoulder arthroscopic subacromial decompression, right elbow lateral extensor fasciotomy and right radial decompression 07/19/13, and right shoulder arthroscopic capsulorrhaphy 07/11/14, per 03/18/15 report. Per 06/26/15 report, the patient is status post right shoulder decompression, date unspecified. The request is for KNEE IMMOBILIZER. RFA with the request not provided. Patient's diagnosis 03/27/15 included right shoulder strain and right shoulder subacromial bursitis, tenosynovitis, and tendinitis. Physical examination to the right shoulder on 03/27/15 revealed diffuse tenderness. Active and passive ranges of motion are guarded in abduction and external rotation. MRI of the right shoulder dated 04/21/15 states "mild rotator cuff tendinosis with chronic SLAP tear superior labrum as the morphology of superior labrum is abnormal. There is mild degenerative change of the AC joint. Intact inferior glenohumeral ligament labral complex. Mild synovitis mid rotator cuff interval with mild tendinosis intraarticular biceps. Normal supraspinatus outlet shown." Treatment to date included shoulder surgeries, imaging studies, physical therapy, injections and medications. Patient's medications include Norco, Tizanidine, Nabumetone, Orphenadrine Citrate, and Terocin patch. The patient is permanent and stationary, per 06/29/15 report. Treatment reports were provided from 10/06/14 - 06/29/15. ODG-TWC, Knee & Leg (Acute & Chronic) Chapter under Immobilization states: "Not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. (Nash, 2004)" Progress report with the request, nor RFA were provided. Treater does not provide medical rationale for the request. There are no physical examination findings nor diagnosis pertaining to the knee or the lower extremity in provided progress reports. Nonetheless, ODG does not recommend immobilization as a primary treatment, and the medical necessity for knee immobilizer is not established with provided documentation. Therefore, the request IS NOT medically necessary.