

Case Number:	CM15-0061861		
Date Assigned:	04/07/2015	Date of Injury:	11/18/2011
Decision Date:	05/29/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	04/01/2015

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 a 43-year-old male, who sustained an industrial injury on 11/18/2011. The mechanism of injury involved continuous trauma. The injured worker was diagnosed as having adhesive capsulitis in the right shoulder. Treatment to date has included right shoulder diagnostic and operative arthroscopy for a full thickness rotator cuff tear on 11/15/2013. Other treatment included physical therapy, home exercise, and a Kenalog injection to the right shoulder on 02/18/2015. The injured worker presented on 02/18/2015 for a follow-up evaluation regarding the right shoulder. The injured worker was status post right shoulder diagnostic and operative arthroscopy. At the prior visit, the physician discussed the option for a Dynasplint system for the right shoulder, as well as 12 additional physical therapy sessions. The injured worker reported progressive symptoms with limited range of motion, persistent pain, and discomfort at night. Upon examination of the right shoulder, there was forward flexion and abduction from 0 degrees to 85 degrees. There was stiffness and pain at end ranges of motion. Internal rotation was not attempted due to stiffness and pain. Recommendations at that time included a Dynasplint system, continuation of the current medication regimen, and an MRI with gadolinium for the right shoulder. A Request for Authorization form was submitted on 02/27/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR Arthrogram (R) shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines regarding MR arthrogram, The Official Disability Guidelines (<http://odg-twc.com/odgtwc/shoulder.htm>).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: California MTUS/ACOEM Practice Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. In this case, the provider indicated the need for updated imaging as there had been no imaging study obtained following the surgery in 11/2013. The injured worker was given a subacromial Kenalog injection on the date of the request. While it is noted that the injured worker has developed stiffness with reduced range of motion of the shoulder, there was no documentation of an attempt at any recent active rehabilitation to address the development of adhesive capsulitis of the shoulder. There was no mention of a surgical indication. There was no evidence of any red flags for serious pathology. Given the above, the request is not medically necessary at this time.

Pain management evaluation and treatment: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state, a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. In this case, the injured worker continues to report persistent right shoulder pain. However, it is noted that the injured worker is currently utilizing Norco, Flector patches, ibuprofen, and Prilosec. There was no indication as to why the injured worker continues to require opioid medication. There was no mention of an attempt to wean the patient from opioid medication. The injured worker was recently given a Kenalog injection for ongoing right shoulder pain. The medical necessity for a pain management consultation has not been established. The request as submitted for review pain management evaluation and treatment would not be supported, as any treatment following the initial evaluation would require separate review. Given the above, the request is not medically necessary.

Dynasplint: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: According to the Official Disability Guidelines, a Dynasplint system is recommended for home use as an option for adhesive capsulitis, in combination with physical therapy instruction. While it is noted that the injured worker maintains a diagnosis of adhesive capsulitis of the right shoulder, there is no documentation of this injured worker's active participation in a rehabilitation program to be used in conjunction with the Dynasplint system. Given the above, the request is not medically necessary.

Flector Patches: 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) - Flector Patches.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state the only FDA approved topical NSAID is diclofenac, which is indicated for the relief of osteoarthritis pain. It has not been evaluated for treatment of the shoulder. The injured worker does not maintain a diagnosis of osteoarthritis. In addition, there is no strength, frequency, or quantity listed in the request. Given the above, the request is not medically necessary.

Prilosec: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no strength, frequency or quantity listed in the request. As such, the request is not medically appropriate.