

Case Number:	CM15-0075130		
Date Assigned:	04/28/2015	Date of Injury:	04/04/2014
Decision Date:	08/05/2015	UR Denial Date:	03/21/2015
Priority:	Standard	Application Received:	04/20/2015

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 46 year old female, who sustained an industrial injury on 4/4/2014. She reported trauma from repetitive movement of the arm. The injured worker was diagnosed as having right shoulder pain with rotator cuff tendinitis, right shoulder bursitis, right shoulder impingement syndrome, right shoulder acromioclavicular joint disorder and right shoulder bicipital tendinitis. Right shoulder magnetic resonance imaging showed lateral outlet stenosis impingement, supraspinatus tendon tear and bursitis. Treatment to date has included physical therapy and medication management. In a progress note dated 3/2/2015, the injured worker complains of severe right shoulder pain. The treating physician is requesting post-operative Keflex, Norco, Tramadol, continuous micro-cook ice machine, interferential unit and supplies, shoulder abduction pillow brace, motorized compression pump and stockings, TENS (transcutaneous electrical nerve stimulation) unit and 12 post-operative physiotherapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Operative Keflex 500mg, 1 tab 4 times daily for 5 days, #20: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 and alternative guidelines were 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 3/2/15 no evidence of a wound infection to warrant antibiotic prophylaxis. The request for Keflex is therefore not medically necessary and appropriate.

Associated surgical service: Shoulder Abduction Pillow Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Shoulder section, Abduction pillow.

Decision rationale: CA MTUS/ACOEM is silent on the issue of abduction pillow. Per the ODG criteria, abduction pillow is recommended following open repair of large rotator cuff tears but not for arthroscopic repairs. In this case there is no indication for need for open rotator cuff repair from the exam note of 3/2/15 and therefore the request is not medically necessary.

Associated surgical service: TENS Unit and Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): s 113-114.

Decision rationale: CA MTUS/ACOEM is silent on the issue of E-stim for the shoulder. Per the ODG, Shoulder, electrical stimulation, "Not recommended. For several physical therapy interventions and indications (e.g., 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.

Associated surgical service: Continuous Micro Cook Machine for Ice: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Knee and Leg 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 amount of days. Therefore the request is not medically necessary.

Associated surgical service: Interferential Current (IFC) Unit and Supplies for the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): s 118-119.

Decision rationale: Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues." As there is insufficient medical evidence regarding use in the postoperative setting, the request is not medically necessary.

Post-Operative Norco 5/325mg, 1 tab every 4-6 hours, #60: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

Decision rationale: The MTUS guidelines under criteria for use of opioids pages 76-78 states, use of opioids should be part of a treatment plan that is tailored to the patient. MTUS pages 60, 61 goes on to state "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." In this the request for Norco as a post-operative medication is medically necessary and recommended for approval.

Associated surgical service: Motorized Compression Pump and Stockings: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Shoulder, Cold compression therapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, Cold compression therapy, it is not recommended in the shoulder as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. As the guidelines do not recommend the requested DME, the request is not medically necessary.

Post-Operative Tramadol 50mg, 1 tab every 4-6 hours, #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): s 93-94.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93- 94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. In this case the use of Tramadol in addition to Norco postoperatively is redundant. Therefore use of Tramadol is not medically necessary.

Post-Operative Physiotherapy (12-sessions, 2 times a week for 6 weeks for the right shoulder): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): s 26-27.

Decision rationale: Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, pages 26- 27, the recommended amount of postsurgical treatment visits allowable are: Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks; Postsurgical physical medicine treatment period: 6 months; Postsurgical treatment, open: 30 visits over 18 weeks; Postsurgical physical medicine treatment period: 6 months; The guidelines recommend "initial course of therapy" to mean one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in the guidelines. In this case the request of 12 is in accordance with one half of 24 visits allowed. Therefore, the request is not medically necessary.