

Case Number:	CM15-0091286		
Date Assigned:	05/18/2015	Date of Injury:	07/31/2014
Decision Date:	08/10/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/13/2015

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: New York
 Certification(s)/Specialty: Neurological 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 41-year-old female who sustained an industrial injury on 07/31/2014. There was no mechanism of injury documented. The injured worker was diagnosed with adhesive capsulitis of the right shoulder with impingement, right acromioclavicular joint cartilage disorder and supraspinatus tendinopathy. Treatment to date includes diagnostic testing with right shoulder magnetic resonance imaging (MRI) in October 2014, physical therapy (12 sessions), steroid injections and medications. According to the primary treating physician's progress report on April 16, 2015 the injured worker continues to experience increasing right shoulder pain with stiffness and decreased range of motion. Examination of the right shoulder demonstrated 90-95 degrees abduction on the right and 165 degrees abduction on the left, 100-110 degrees flexion in the right shoulder and 165 on the left shoulder. Internal and external rotation was restricted by 50 percent with exquisite tenderness over the lateral acromion in the region of the subacromial bursa and the anterolateral of the acromion on the right side. Flexion, adduction and internal rotation caused significant pain. Current medications were not documented. Treatment plan consists of the authorized arthroscopy of the shoulder for rotator cuff repair, post-operative physical therapy for 12 sessions, Tylenol #3, postoperative antibiotics and the current request for post-operative acupuncture therapy for 12 sessions, Interferential Current (IFC) unit, MicroCool machine, transcutaneous electrical nerve stimulation (TEN's) unit, motorized compression pump and stockings for 2-4 weeks, shoulder abduction pillow, brace, and transportation to and from medical clearance and surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 post-operative acupuncture treatments: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints, Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Page(s): 79-81 and 116-120, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Low Back Chapter, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter-Rotator cuff repair.

Decision rationale: The ODG guidelines list criteria for a rotator cuff repair. First the imaging should show a rotator cuff tear. Documentation does not contain evidence which fulfills these criteria. Documentation does not show three months of continuous conservative treatment or six months of intermittent treatment. The California MTUS guidelines recommend for surgical consideration that clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair, be found. Documentation does not fulfill this criterion. The requested treatment: Rotator cuff repair is not medically necessary and appropriate.

Transportation to and from medical clearance and surgery: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Durable medical equipment: Shoulder abduction pillow brace: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Durable medical equipment: Motorized compression pump and stockings for 2-4 weeks:
Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Durable medical equipment: MircoCool machine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Durable medical equipment: TENS unit with supplies: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Durable medical equipment: IFC unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.