

Case Number:	CM15-0095009		
Date Assigned:	05/22/2015	Date of Injury:	04/15/2009
Decision Date:	08/13/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	05/18/2015

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 53-year-old female, who sustained an industrial injury on 4/15/2009, as a result of cumulative trauma. The injured worker was diagnosed as having spondylosis of unspecified site without myelopathy, displacement of lumbar and thoracolumbar intervertebral disc without myelopathy, and other affections of shoulder region, not elsewhere classified. Treatment to date has included diagnostics, injections, and medications. Currently, the injured worker reported no relief from recent corticosteroid injection (right shoulder on 3/03/2015). Magnetic resonance imaging of the right shoulder (7/28/2011) was documented as showing a thinning and very regular appearance involving the anterior leading edge of the supraspinatus tendon near its insertion into the greater tuberosity. Per the progress report, dated 3/17/2015, magnetic resonance imaging findings from 8/12/2014 noted a small partial thickness tear of the distal right supraspinatus tendon, also with mild tendinosis of the remainder of supraspinatus tendon. Physical exam noted exquisite tenderness over the entire lateral aspect of the acromion and painful range of motion. 1cm atrophy of the right humeral girth was noted when compared to the left and she was right hand dominant. The treatment plan included right shoulder manipulation under anesthesia, arthroscopic partial resection distal clavicle, partial anterolateral acromioplasty, resection of coracoacromial ligament, and extensive debridement. Post-operative care recommended care included a home exercise kit, acupuncture (2x6), microcool unit, shoulder abduction brace, deep vein compression pump with stockings/sleeves, and interferential unit with supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Postop Home Exercise Kit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

Decision rationale: CA MTUS/Chronic Pain Medical Treatment Guidelines, Exercise page 46 and 47 state the exercise is recommended. "There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen". As the guidelines do not recommend any particular exercise program, there is lack of medical necessity for a home exercise kit. Therefore, determination is not medically necessary.

Postop acupuncture 2x6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per the MTUS Acupuncture Medical Treatment Guidelines, pages 8&9. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e). The guidelines specifically report 3-6 treatments initially. As the request is for 12 visits the determination is not medically necessary.

Postop Microcool unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 367-377.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder 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 determination is not medically necessary.

Postop shoulder abduction brace: 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), Shoulder chapter, Postoperative abduction pillow sling.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder 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 exceeds the guidelines recommendation of 7 days. Therefore the determination is not medically necessary..

Postop DVT compression pump with stockings/sleeves: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Prevention of Venous Thromboembolic Disease - Anticoagulant Medication.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (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 determination is not medically necessary.

Postop interferential unit with supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(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-interpretible for recommendation due to poor study design and/or methodologic issues". As there is insufficient medical evidence regarding use in the postoperative shoulder, the determination is not medically necessary.