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| Case Number: | CM13-0014339 | | |
| Date Assigned: | 10/02/2013 | Date of Injury: | 01/27/2013 |
| Decision Date: | 02/13/2014 | UR Denial Date: | 08/06/2013 |
| Priority: | Standard | Application Received: | 08/20/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 physician 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/services.

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 claimant is a 55-year-old female who sustained an injury to the left shoulder and neck in a work related accident on 01/27/13. Clinical records for review identified a recent progress report of 07/12/13 at which time the claimant was seen by [REDACTED] for continued complaints of neck pain, bilateral shoulder and low back pain. Examination showed the cervical spine with paracervical tenderness to palpation, 5/5 motor strength, and no reflexive or sensory loss. Evaluation of the left shoulder showed a negative O'Brien's speed testing with no crepitation, positive acromioclavicular (AC) joint tenderness to palpation and pain with crossover testing with resisted adduction, and strength at 4/5. The claimant was diagnosed with left shoulder impingement and rotator cuff tendinosis as well as cervical strain with lumbar complaints. Surgery in the form of left shoulder arthroscopy, decompression and AC joint resection was recommended because of failed conservative care including injections. Also recommended were cervical epidural injections "times two" for the claimant's ongoing cervical symptomatology. Previous imaging included an MRI of the left shoulder from April 2013 showing supra and infraspinatus tendinosis with tearing of the superior labrum and underlying arthrosis. The cervical MRI was also reviewed from April 2013 showing disc protrusions at C4-5 and C6-7 with facet changes and stenosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy, subacromial decompression, (acromioclavicular) AC joint resection: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation ODG, Surgery Chapter, Surgery for Impingement Syndrome

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 18th Edition; 2013; Chapter shoulder

Decision rationale: Based on California ACOEM Guidelines and supported by Official Disability Guidelines criteria, the role of the proposed surgical process appears medically necessary. The claimant's MRI scan demonstrates impingement findings as well as AC joint degenerative change. This, coupled with the documented six months of conservative care that has included previous injection therapy, would support the acute role of the surgical request in question.

Postoperative physical therapy three (3) times a week for six (6) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: Based on California MTUS Postsurgical Rehabilitative Guidelines, 18 sessions of initial physical therapy would not be indicated. Given the initial one half role of therapy in the postoperative setting, guideline criteria would recommend the role of up to 12 sessions over a 14 week period of time. The initial request for 18 sessions would exceed guideline criteria and would not be indicated.

Ice therapy three (3) times a week for six (6) weeks: 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 (ODG), Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates, Shoulder Procedure, Continuous-flow cryotherapy

Decision rationale: California MTUS Guidelines are silent. When looking at Official Disability Guidelines, six week rental of a cryotherapy device or "ice therapy" would not be indicated. Records would not support the role of cryotherapy for that significant a period of time. ODG Guideline criteria would only recommend its role for the first seven days including home use. This specific request in this case would not be indicated.

Cervical epidural steroid injection times two (2): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: Based on MTUS Chronic Pain Guidelines, epidural injection times two would not be indicated. First and foremost, the claimant's physical examination fails to demonstrate a radicular process to the upper extremity when coupled with the fact that multiple injections are being requested. This specific request would not be indicated. MTUS Guidelines only recommend the role of repeat injections based on functional response of at least 50%. The request for two injections of the cervical spine in absence of radicular findings would not be indicated