

Case Number:	CM13-0024785		
Date Assigned:	12/04/2013	Date of Injury:	08/24/2011
Decision Date:	01/29/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	09/16/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and Texas. 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. He/She is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 55-year-old female who reported an injury on 08/24/2011; the mechanism of injury was not stated. The patient is diagnosed with bilateral carpal tunnel syndrome, chronic left shoulder impingement, status post rotator cuff, subacromial decompression, distal clavicle resection, debridement, with ongoing subacromial pain. On 06/29/2012, the patient underwent and arthroscopic distal clavicle excision with subacromial decompression and bursectomy of the left shoulder. On 04/10/2013, the patient was evaluated for a second opinion. She is noted to complain of ongoing left shoulder pain noting it had been 10 months since her shoulder surgery and she complained of pain primarily in the lateral aspect of her shoulder, pain with reaching and lifting, and pain sleeping on her side. She reported some pain even at rest but it was dramatically aggravated with activity. She is have undergone a left shoulder surgery and to have had extensive postoperative physical therapy following the surgery without improvement. On physical exam, the patient was noted to have decreased range of motion of the left shoulder with flexion of 145 degrees, extension of 40 degrees, abduction of 110 degrees, internal rotation at 70 degrees, and external rotation at 80 degrees. There was subacromial tenderness and some moderate acromioclavicular joint tenderness, minimal glenohumeral tenderness, no biceps tenderness. The patient was noted to have a positive impingement test and slight weakness of rotator cuff strength in abduction and external rotation secondary to pain. Fluoro scan impingement series of the left shoulder performed on that date noted the glenohumeral joint was unremarkable and the patient had a well resected distal clavicle and subacromial decompression with no proximal humeral migration and no calcifications noted. The patient is noted to have treated previously with 2 cortisone injections with short-term relief. Prior to her surgery, a left shoulder injection

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery-Shoulder left arthroscopy debridement: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The patient is a 55-year-old female who reported an injury to her left shoulder on 08/24/2013. She is noted to have initially treated conservatively with physical therapy and cortisone injections without improvement and to have undergone a subacromial decompression, distal clavicle excision, and bursectomy on 06/29/2012 followed by extensive physical therapy without improvement. She is noted to continue to complain of left shoulder pain and to have received a subacromial joint injection on 05/01/2013 with good relief of pain and to have undergone an MRI that showed moderate rotator cuff tendinosis and moderate to severe biceps tendinosis with mild capsular thickening and increased signal suggesting mild adhesive capsulitis. On physical exam, the patient is noted to have mild to moderate decrease in range of motion of the right shoulder with flexion at 140 degrees, abduction at 110 degrees, internal rotation at 70 degrees and external rotation at 79 degrees. A request was submitted for an arthroscopic debridement. The California MTUS Guidelines state for partial thickness tears or small full thickness tears presenting primarily as impingement surgery is reserved for cases failing conservative care for 3 months and the preferred procedure is usually arthroscopic decompression which involves debridement of the inflamed tissue; however, as the patient is not noted to have weakness on arm elevation or rotation or to have findings of partial thickness or small full thickness tears presenting as impingement, the requested surgery does not meet guideline recommendations. Based on the above, the request for surgery left shoulder arthroscopic debridement, quantity 1, is non-certified.

Surgery-Shoulder lysis and resection of adhesions: 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) Shoulder (Acute & Chronic), Surgery for adhesive capsulitis.

Decision rationale: The patient is a 55-year-old female who reported an injury to her left shoulder on 08/24/2011. She is noted to have initially treated conservatively with physical therapy and cortisone injections and then to have undergone a left shoulder subacromial decompression, arthroscopic bursectomy, and distal clavicle excision on 06/29/2012 followed by 24 sessions of postoperative physical therapy and treatment with medications. She is reported to

have continued complaints of ongoing pain. She is noted to have decreased range of motion of the left shoulder but no loss of strength and to have received additional cortisone injections with temporary relief of pain. The patient is noted to have undergone an MRI on 09/20/2013 that showed moderate rotator cuff tendinosis, moderate to severe biceps tendinosis, and mild capsular thickening and increased signal suggesting mild adhesive capsulitis. On range of motion testing, the patient is noted to have 140 degrees of flexion, 110 degrees of abduction, and normal intact rotator cuff strength. The California MTUS Guidelines do not address surgery for adhesive capsulitis. The Official Disability Guidelines recommend arthroscopic release of adhesions in cases failing conservative care; however, as the patient is not noted to have range of motion of less than 90 degrees of abduction, the requested surgery for adhesive capsulitis does not meet guideline recommendations. Based on the above, the request for surgery/shoulder lysis and resection of adhesions, quantity 1, is non-certified.

Physical Therapy post-op left shoulder QTY: 12 for 2 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 Page(s): 26-27.

Decision rationale: The patient was noted to be planned for a left shoulder debridement and lysis and resection of adhesions and a request for postoperative physical therapy was submitted. However, as the requested surgery is not indicated, the need for postoperative PT is not established. Based on the above, the request for physical therapy post-op left shoulder, quantity 12 for 2 weeks, is non-certified.

DME (Durable Medical Equipment) Game Ready Unit: 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) Shoulder (Acute & Chronic), Cold compression therapy.

Decision rationale: The patient was reported to be planned for a left shoulder debridement with lysis and resection of adhesions and a request was submitted for postoperative DME, a game ready unit. The California MTUS Guidelines does not address the request. The Official Disability Guidelines do not recommend cold compression therapy units. As the surgery has not been certified the need for postoperative DME is not established. Based on the above, the request for DME (durable medical equipment) game ready unit is non-certified.

Medical Treatment-pre op appointment: 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) Low Back - Lumbar & Thoracic (Acute & Chronic), Preoperative testing, general

Decision rationale: The patient is noted to have been planned for a left shoulder debridement with lysis and resection of adhesions. However, as the requested surgery has not been certified, the need for a preoperative appointment is not established. Based on the above, the request for medical treatment/pre-op appointment is non-certified.