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| Case Number: | CM13-0027504 | | |
| Date Assigned: | 11/22/2013 | Date of Injury: | 01/25/2010 |
| Decision Date: | 01/22/2014 | UR Denial Date: | 08/23/2013 |
| Priority: | Standard | Application Received: | 09/23/2013 |

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. 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 sixty three year old gentleman who injured his left shoulder on 01/25/10. Records for review include a 08/12/13 reassessment to the left shoulder with [REDACTED] where the claimant is noted to be with subjective complaints of pain and weakness, worse with overhead activities. It indicates that he has been nonresponsive to conservative care that has included physical therapy, chiropractic measures, acupuncture, antiinflammatory agents, as well as prior corticosteroid injections. Objective findings demonstrated diminished range of motion and weakness with positive impingement signs. Review of a prior Magnetic Resonance Imaging report of 05/30/13 showed tendinosis to the supraspinatus as well as long head of the bicep tendon. Based on failed conservative measures, surgical arthroscopy to the shoulder with subacromial decompression was recommended for further care.

IMR ISSUES, DECISIONS AND RATIONALES

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

One left shoulder arthroscopy with possible subacromial decompression: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

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

Decision rationale: Based on California American College of Occupational and Environmental Medicine (ACOEM) Guidelines, surgical process to include arthroscopy and subacromial decompression appears warranted. The claimant is with positive Magnetic Resonance Imaging scan, failed conservative care including injection therapy for greater than six months, and a positive physical examination supportive of impingement. The available clinical information would support a medical necessity for the requested intervention.

One medical clearance with labs: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Section: Independent Medical Examinations and Consultations, page 127 and Official Disability Guidelines (ODG) 18th Edition, 2013, Section: Low Back Procedure

Decision rationale: Based on California American College of Occupational and Environmental Medicine (ACOEM) Guidelines and supported by Official Disability Guidelines criteria, medical clearance would be appropriate however a general request for laboratory studies absent documentation of specific clinical indications for the testing would not be considered as medically necessary.

Twelve post-op physical therapy sessions: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG).

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: Based on California Medical Treatment Utilization Schedule (MTUS) Postsurgical Rehabilitative Guidelines, twelve initial sessions of physical therapy would be medically necessary. Given the one half role of initial therapy and guideline criteria that would recommend up to twenty four sessions over a fourteen week period of time, the initial Twelve sessions would appear medically necessary per California Medical Treatment Utilization Schedule (MTUS) Section: Postsurgical Rehabilitative Guidelines.

One abduction pillow/ sling: 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) 18th Edition, 2013, Section: Shoulder Procedure

Decision rationale: Based on the California Medical Treatment Utilization Schedule (MTUS) Guidelines with respect to postoperative immobilization, when looking at Official Disability Guidelines criteria, an abduction sling would not be indicated. Abduction slings are only indicated for massive or large rotator cuff repair procedures. Clinical records in this case indicate the need for surgical arthroscopy and a subacromial decompression. The role of this speciality postoperative immobilization device for the shoulder would not meet clinical criteria and would not be supported at present.

One cold therapy unit: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 18th Edition, 2013, Section: Shoulder Procedure

Decision rationale: Based on Official Disability Guidelines criteria, as California Medical Treatment Utilization Schedule (MTUS) Guidelines are silent, a cryotherapy unit in this case would not be indicated. While guidelines would recommend the role of seven day rental of a cryotherapy device in the postoperative setting of shoulder procedure, the requested number of days for postoperative use in the request at hand is not documented. Guidelines would not recommend the role of purchase of the above device or use beyond seven days. The lack of clinical parameters in regard to request would not support its need at this time.