MAXIMUS Federal Services

Case Number:	CM13-0037214		
Date Assigned:	12/13/2013	Date of Injury:	01/06/2007
Decision Date:	02/28/2014	UR Denial Date:	09/17/2013
Priority:	Standard	Application Received:	09/26/2013

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 has a subspecialty in shoulder and elbow 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 56-year-old male who reported an injury on 01/06/2007. The mechanism of injury was not provided for review. The patient underwent a MRI of the left shoulder in 07/2012 that revealed a full thickness tear of the supraspinatus tendon and a tear of the superior glenoid labrum. Previous treatments included activity modification, physical therapy, medications, and subacromial injections. It is also noted that the patient underwent right shoulder subacromial decompression/Mumford/rotator cuff debridement in 10/2011. The patient's most recent clinical findings included restricted range of motion of the bilateral shoulders with tenderness over the acromioclavicular joint and bicipital groove. The patient's diagnoses included bilateral shoulder pain with possible impingement. The patient's treatment plan included arthroscopic rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

left shoulder arthroscopic subacromial decompression: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines, 18th edition 2013

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: The requested left shoulder arthroscopic subacromial decompression is medically necessary and appropriate. The clinical documentation submitted for review does provide evidence that the patient has a full thickness tear that has been recalcitrant to conservative treatments. The American College of Occupational and Environmental Medicine states "the preferred procedure is usually arthroscopic decompression which involves debridement of inflamed tissue, burning of anterior acromion, lysis and sometimes removal of the coracoacromial ligament, and possible removal of the outer clavicle." The clinical documentation submitted for review does provide evidence that the patient has physical findings consistent with a small full thickness tear. The patient does have tenderness to palpation over the acromioclavicular joint with restricted range of motion and a positive impingement sign. Therefore, the need for left shoulder arthroscopic subacromial decompression is indicated. As such, the requested left arthroscopic subacromial decompression is medically necessary and appropriate.

Mumford procedure: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines, 18th edition 2013.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 210-211.

Decision rationale: The requested Mumford procedure is medically necessary and appropriate. The clinical documentation submitted for review does provide evidence that the patient has a full thickness tear that has been recalcitrant to conservative treatments. The American College of Occupational and Environmental Medicine states "the preferred procedure is usually arthroscopic decompression which involves debridement of inflamed tissue, burning of anterior acromion, lysis and sometimes removal of the coracoacromial ligament, and possible removal of the outer clavicle." The clinical documentation submitted for review does provide evidence that the patient has physical findings consistent with a small full thickness tear. The patient does have tenderness to palpation over the acromioclavicular joint with restricted range of motion and a positive impingement sign. Therefore, the need for Mumford procedure is indicated. As such, the requested left arthroscopic subacromial decompression is medically necessary and appropriate.

Pain pump: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines, 18th edition 2013

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Postoperative pain pump.

Decision rationale: The requested pain pump is not medically necessary or appropriate. Official Disability Guidelines do not support the use of a postoperative pain pump status post shoulder surgery as there is little scientific evidence to support the efficacy of this type of treatment over oral medications. The clinical documentation submitted for review does not provide any exceptional factors to extend treatment beyond guideline recommendations. As such, the requested pain pump is not medically necessary or appropriate.

Pro-sling: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines, 17th edition 2012

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Postoperative abduction pillow sling.

Decision rationale: The requested Pro sling is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is a surgical candidate. However, it is noted within the documentation that the patient's injury can be repaired arthroscopically. Official Disability Guidelines do not recommend the use of a postoperative abduction pillow sling for arthroscopic repairs. This type of sling is only recommended for open repair of large and massive rotator cuff tears. Although the patient may benefit from a short course of immobilization following the surgical intervention, this type of sling would be considered excessive. As such, the requested Pro sling is not medically necessary or appropriate.

Abduction pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines, 18th edition 2013

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Postoperative abduction pillow sling.

Decision rationale: The requested Abduction pillow is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is a surgical candidate. However, it is noted within the documentation that the patient's injury can be repaired arthroscopically. Official Disability Guidelines do not recommend the use of a postoperative abduction pillow sling for arthroscopic repairs. This type of sling is only recommended for open repair of large and massive rotator cuff tears. Although the patient may benefit from a short course of immobilization following the surgical intervention, this type of sling would be considered excessive. As such, the requested Abduction pillow is not medically necessary or appropriate.

Post-operative medication: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines, 18th edition 2013.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: The requested postoperative medication is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is a surgical candidate. The American College of Occupational and Environmental Medicine recommends medications to manage a patient's acute pain which would be related to the patient's surgical intervention. However, the request as it is written does not specifically provide the type of medication that would be used in the management of the patient's postsurgical pain. Therefore, efficacy and safety cannot be determined. As such, the requested postoperative medication is not medically necessary or appropriate.

Motorized hot/cold therapy unit for 30 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines, 18th edition 2013.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous Flow Cryotherapy.

Decision rationale: The requested motorized hot/cold therapy unit for 30 days is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is a surgical candidate. Official Disability Guidelines recommend the use of a continuous cryotherapy unit for up to 7 days in the postsurgical management of a patient after shoulder surgery. The request is for 30 days. This exceeds guideline recommendations. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested motorized hot/cold therapy unit for 30 days is not medically necessary or appropriate.