

Case Number:	CM13-0043096		
Date Assigned:	12/27/2013	Date of Injury:	02/01/2012
Decision Date:	03/27/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	10/30/2013

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 Hand Surgery and is licensed to practice in 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 36 year old male who reported an injury on 02/01/2012 after he was hit with a crowbar. The patient reportedly sustained injury to the right shoulder. The patient ultimately underwent surgical intervention in 11/2012 for a SLAP repair and a cubital tunnel release in 06/2013. The patient did receive postoperative physical therapy. Due to persistent pain complaints of the right shoulder, an MRI in 09/2013 was performed. This MRI concluded there was no full-thickness tear or atrophy of the rotator cuff, there was mild tendinosis involving the supraspinatus and infraspinatus tendons, there was a significant complex tear of the posterior superior labrum with paralabral cysts and thickening of the inferior glenohumeral ligament with type 3 acromion processes with anterior distal hooking. The patient's treatment history for the right shoulder has included a TENS unit, physical therapy, medications, and a subacromial injection. The patient's most recent clinical examination findings included active forward elevation to 150 degrees, abduction to 120 degrees, and external rotation to 45 degrees with tenderness to palpation along the acromioclavicular joint. The patient's treatment plan included arthroscopic subacromial decompression and distal clavicle resection of the right shoulder followed by the use of a co-therapy unit and a shoulder immobilizer.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Subacromial Decompression and Distal Clavicle Resection of the Right Shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

Decision rationale: The requested arthroscopic subacromial decompression and distal clavicle resection of the right shoulder is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommends surgical intervention for impingement syndrome when the patient has activity limitations of longer than 4 months with evidence of a surgical lesion, both upon physical examination and imaging study that would benefit from surgical intervention that has failed to respond to conservative treatments. The clinical documentation submitted for review does include an MRI that provides clear imaging evidence of an impingement that would benefit from surgical intervention. Additionally, the patient does have tenderness to palpation over the acromioclavicular joint with range of motion limitations that have failed to respond to conservative treatment modalities, to include medications, physical therapy, a TENS unit, and subacromial injections. Therefore, the need for surgical intervention is supported. As such, the requested arthroscopic decompression and distal clavicle resection of the right shoulder is medically necessary and appropriate.

Ice Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The requested ice therapy is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do recommend alteration of ice and heat therapy status post a shoulder injury. Additionally, Official Disability Guidelines do recommend up to 7 days of a continuous flow cryotherapy unit after a patient has had shoulder surgery. However, the request as it is written does not clearly identify what type of ice therapy is needed for this patient. Additionally, an intended duration of treatment is not provided. Therefore, medical necessity cannot be established. As such, the requested ice therapy is not medically necessary or appropriate.

Shoulder Immobilizer: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

Decision rationale: The requested shoulder immobilizer is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do recommend short courses of immobilization after an acute injury. Therefore, a short period of immobilization would be indicated in the postsurgical management of this type of surgery. However, the request as it is written does not clearly identify what type of immobilization is being requested. Additionally, there is no documentation of an intended duration to support the medical necessity. As such, the requested shoulder immobilizer is not medically necessary or appropriate.