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| Case Number: | CM13-0045760 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 06/15/2004 |
| Decision Date: | 03/26/2014 | UR Denial Date: | 11/05/2013 |
| Priority: | Standard | Application Received: | 11/12/2013 |

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 Surgeon 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 58-year-old female who reported injury on 06/15/2004. The mechanism of injury was stated to be a continuous trauma from 10/02/1986 through 04/20/2004. The patient was noted to have undergone cortisone injections, physical therapy, anti-inflammatory medications, and the passage of time. The patient was noted to have an MRI scan of the left shoulder without contrast on 07/26/2013 which revealed a complete tear of the distal supraspinatus and infraspinatus portions of the rotator cuff with chronic subacromial impingement. The patient was noted to have decreased range of motion in flexion, extension, abduction, adduction, external rotation, and internal rotation. The patient was noted to have severe supraspinatus tenderness and moderate greater tuberosity tenderness. The patient was noted to have severe AC joint tenderness and mild biceps tendon tenderness. The patient was noted to have subacromial crepitus. The patient was noted to have painful shoulder movement. The patient was noted to have a positive AC joint compression test, impingement 1, 2, and 3 tests. Diagnosis was noted to be a right full thickness rotator cuff tear with chronic subacromial impingement status post continuous trauma injury. The request was made for a right shoulder arthroscopic evaluation, arthroscopic rotator cuff debridement and/or repair as indicated, subacromial decompression, distal clavicle resection, preoperative medical clearance, postoperative therapy, CPM, Surgi-Stem unit, Cool Care cold therapy unit, large abduction pillow, and Lidoderm patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic evaluation .: 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): 210-2011..

Decision rationale: ACOEM Guidelines indicate that a surgical consultation may be indicated for patients who have a red flag condition, activity limitation for more than 4 months plus existence of a surgical lesion, and failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion as well as clear clinical and imaging evidence of a lesion that has been shown to benefit in both the long and short-term from surgical repair. As ACOEM Guidelines do not address right shoulder arthroscopic evaluation, diagnostic arthroscopy, secondary guidelines were sought. Official Disability Guidelines indicate that diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. The clinical documentation submitted for review indicated the patient had clear evidence of a rotator cuff tear per the MRI; however, the MRI was not provided for review. Per the submitted request, the side that treatment was being requested for was not provided. Given the above, the request for right shoulder arthroscopic evaluation is not medically necessary.

Subacromial decompression: 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): 210-211..

Decision rationale: ACOEM Guidelines indicate that a surgical consultation may be indicated for patients who have a red flag condition, activity limitation for more than 4 months plus existence of a surgical lesion, and failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion as well as clear clinical and imaging evidence of a lesion that has been shown to benefit in both the long and short-term from surgical repair. ACOEM Guidelines indicate surgery for impingement is usually arthroscopic decompression and it is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care including cortisone injections can be carried out for 3 to 6 months before considering surgery. Clinical documentation submitted for review indicated the patient had trialed and failed conservative therapy. However, as it is on the continuum with rotator cuff conditions, there was a lack of documentation of the official MRI to indicate the patient had a rotator cuff tear. The request as submitted was for an unstated shoulder. Given the above, the request for subacromial decompression is not medically necessary.

Arthroscopic rotator cuff debridement and or repair.: 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.

Decision rationale: ACOEM Guidelines indicate that a surgical consultation may be indicated for patients who have a red flag condition, activity limitation for more than 4 months plus existence of a surgical lesion, and failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion as well as clear clinical and imaging evidence of a lesion that has been shown to benefit in both the long and short-term from surgical repair. ACOEM Guidelines indicate surgery for impingement is usually arthroscopic decompression and it is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care including cortisone injections can be carried out for 3 to 6 months before considering surgery. Clinical documentation submitted for review indicated the patient had trialed and failed conservative therapy. However, as it is on the continuum with rotator cuff conditions, there was a lack of documentation of the official MRI to indicate the patient had a rotator cuff tear. The request as submitted was for an unstated shoulder. Given the above, the request for subacromial decompression is not medically necessary.

Distal clavicle resection .: 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 Chapter, Partial Claviclectomy.

Decision rationale: Official Disability Guidelines indicate that for a partial claviclectomy, the patient should have at least 6 weeks of care directed towards symptom relief prior to surgery, pain at the AC joint, aggravation of pain with shoulder motion or carrying weight, or previous grade 1 or grade 2 AC separation plus tenderness at the AC joint and/or pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial plus conventional films showing either posttraumatic changes of the AC joint or severe DJD of AC joint or complete or incomplete separation of the AC joint and bone scan is positive for AC joint separation. The clinical documentation submitted for review indicated the patient had failed injection of steroids; however, there was a lack of documentation indicating the patient had an injection of anesthetic for a diagnostic therapeutic trial. Additionally, there was a lack of documentation indicating the patient had AC joint changes as the MRI was not submitted for review nor were x-rays. There was a lack of documentation indicating which shoulder would be treated. Given the above, the request for distal clavicle resection is not medically necessary..

Pre-Op medical clearance: 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 The Physician Reviewer based his/her decision on <http://www.choosingwisely.org/?s=preoperative+surgical+clearance&submit=>.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op therapy x12 ':

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): 12..

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Chronic Pain Management (CPM): 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): 12..

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Surgi-Stim unit .:

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NMES. Page(s): 121..

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Coolcare cold therapy 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 Chapter, Continuous Flow Cryotherapy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Large abduction pillow .: 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 Chapter, Postoperative abduction pillow sling.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Lidoderm patch 5 % #60.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm. Page(s): 56, 57..

Decision rationale: California MTUS Guidelines indicate that Lidoderm is a second tier medication for neuropathic pain. There was a lack of documentation indicating the patient had trialed first tier medications and failed them. Given the above, the request for Lidoderm patch 5%, #60 is not medically necessary.