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| Case Number: | CM13-0055239 | | |
| Date Assigned: | 04/25/2014 | Date of Injury: | 06/26/2002 |
| Decision Date: | 06/12/2014 | UR Denial Date: | 10/29/2013 |
| Priority: | Standard | Application Received: | 11/20/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert 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 expert 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 49-year-old female who sustained an injury to the right upper extremity on 06/25/02. The records provided for review document that following conservative care, the claimant underwent right shoulder arthroscopy, subacromial decompression, debridement of SLAP lesion, distal clavicle excision and debridement of an undersurface partial thickness rotator cuff tear on 02/08/12. Postoperatively, the claimant developed chronic regional pain syndrome and a 04/29/13 progress report documented hypersensitivity and allodynia along the right shoulder into the distal right upper extremity and diminished strength. A recent progress report on 01/07/14 indicated continued complaints of pain and swelling of the right shoulder despite conservative care that included multiple prior stellate ganglion blocks. Physical examination revealed the right shoulder to have 110 degrees of abduction and 90 degrees of forward flexion and negative impingement, O'Brien's and supraspinatus testing. There was a positive Tinel's sign of the right wrist and 4/5 strength with wrist flexion and extension. No further shoulder examination findings were noted. Working assessment was chronic regional pain syndrome following right shoulder arthroscopy. The recommendation was made for placement of a spinal cord stimulator as conservative care ad failed. It was noted that prior to the 01/07/14 assessment, the recommendation was made for a second shoulder arthroscopy, capsular release and manipulation under anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: California ACEOM Guidelines would not support a right shoulder arthroscopy. This individual has a working diagnosis of chronic regional pain syndrome. The records provided for review do not contain any documentation of acute shoulder findings on examination or postoperative imaging to support the need for further intervention. While the most recent examination identifies restricted range of motion, abduction is to 110 degrees which would not support the need for manipulation under anesthesia. Based on the lack of documentation of postoperative imaging and the presence of clinical findings consistent with chronic regional pain syndrome and not acute internal shoulder pathology, the proposed right shoulder arthroscopy cannot be recommended as medically necessary.

POST OP PHYSICAL THERAPY X 12: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

ARTHROSCOPIC CAPSULAR RELEASE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Procedure- Surgery For Adhesive Capsulitis.

Decision rationale: The California MTUS and ACOEM Guidelines do not address this request. The Official Disability Guidelines do not support the role of any form of arthroscopic intervention for adhesive capsulitis. The role of a capsular release in this instance would not be indicated.

MANIPULATION UNDER ANESTHESIA: 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)-

Treatment In Worker's Compensation, Online Edition Chapter: Shoulder (Updated 2/14/12)
Manipulation Under Anesthesia (MUA).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL Disability Guidelines (ODG), Shoulder Procedure- Manipulation Under Anesthesia.

Decision rationale: The California MTUS and ACOEM Guidelines do not address this topic. The Official Disability Guidelines would not recommend and manipulation under anesthesia for this claimant. As stated above, this claimant's clinical picture is inconsistent with need for further shoulder intervention including manipulation under anesthesia with current range of motion demonstrating abduction of 110 degrees. The role of manipulation would not be indicated.

PRE OP CLEARANCE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

SURGI STIMX 90 DAYS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

COOLCARE 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 cite any medical evidence for its decision.

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

CPM X 45 DAYS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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