

Case Number:	CM13-0055241		
Date Assigned:	12/30/2013	Date of Injury:	03/09/2010
Decision Date:	03/12/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	11/15/2013

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 60-year-old female status post injury on March 9, 2010. Prior treatment history has included medications, physical therapy and surgical intervention. The patient is status post right shoulder subacromial decompression and distal clavicle resection as well as post right carpal tunnel release. The diagnostic studies have included an MRI of the left shoulder performed October 29, 2013 which revealed a 2.5 mm partial thickness interest substance tear at the supraspinatus tendon, mild subscapularis tendinosis, marked AC arthrosis and mild subdeltoid bursitis. The MRI of the lumbar spine performed October 29, 2013 revealed disc protrusions at L1-2, L2-3 and L3-4. The MRI of the cervical spine performed October 29, 2013 revealed broad based disc protrusions from C5 to C7. On September 4, 2013 the patient's treating physician requested authorization for left shoulder arthroscopy subacromial decompression and distal clavicle resection, called therapy rental for four weeks, physical therapy two times a week for four weeks and a home therapy exercise kit. Upon examination the patient had decreased range of motion in flexion and abduction and internal rotation; there is tenderness noted in the anterior aspect of the left shoulder as well as a positive impingement sign. The patient's complaints included pain in the left shoulder which she rates a 7 out of 10. The patient was previously approved for left shoulder surgery in the past due to rotator cuff tendinosis however due to personal issues she was unable to proceed at that time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy, subacromial decompression and distal clavicle resection:

Overtured

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 & 214.

Decision rationale: Surgical considerations depend on the working or imaging confirmed diagnosis. The patient has a reported partial thickness tear at the mid supraspinatus tendon and has documented complaints of pain, limitation and range of motion, and positive tenderness in the anterior aspect of the left shoulder and left deltoid. The guidelines further state that patient should have conservative treatment prior to undergoing surgical intervention. The patient has had left shoulder injections within the past three months prior to this request and has also had home exercise regimens and bio freeze. According to the guidelines listed above and the clinical criteria the request for surgery is certified.

Cold therapy rental for four (4) weeks, Ultra 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) Shoulder, Cryotherapy Units.

Decision rationale: According to the Official Disability Guidelines the request for a cold therapy rental for four weeks is noncertified. The guidelines allow for seven days post operative use, including home use. This request exceeds the allowable amount of time.

Purchase of a home therapy exercise kit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

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

Decision rationale: According to the Official Disability Guidelines the request for an exercise kit is noncertified. There is no indication that the patient has had proper instructions for at home exercise program or what type/items will be included in the kit.

Physical therapy two times a week for four weeks for the left shoulder: Overtured

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: According to the California medical treatment utilization schedule the request for physical therapy two times a week for four weeks fits within the guidelines. The guidelines state physical medicine is medically necessary and initial course of therapy may be prescribed.