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| Case Number: | CM13-0055869 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 05/03/2013 |
| Decision Date: | 03/18/2014 | UR Denial Date: | 10/28/2013 |
| Priority: | Standard | Application Received: | 11/21/2013 |

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:

According to the records made available for review, this is a 54-year-old male with a 5/3/13 date of injury. At the time of request for authorization for Right Shoulder ASAD/DCR evaluation of rotator cuff and 12 visits of postoperative chiropractic therapy, and follow-up in 6 weeks, there is documentation of subjective (worsening right shoulder pain, difficulty sleeping due to pain, and limited ability to do any overhead activities) and objective (decreased range of motion of the right shoulder, weakness with abduction, tenderness of the biceps and AC joint, positive cross-arm testing, positive bursitis and impingement signs, and 4/5 strength in all quadrants) findings, imaging findings (MRI of the right shoulder (7/13/13) report revealed partial tear of the superior fibers of the subscapularis tendon near its insertion with medial subluxation of the long-head of the biceps tendon, tendinosis involving the supraspinatus and infraspinatus tendon, and type II acromion with mild degenerative changes of the AC joint), current diagnoses (right shoulder bursitis and impingement, right symptomatic AC joint, and subscapularis tendon partial tear), and treatment to date (chiropractic treatment, physical therapy, medication, and home exercise program). Report indicates the patient denied an injection. Plan indicates right shoulder arthroscopic subacromial decompression, distal clavicle resection and rotator cuff repair, and twelve visits of postoperative chiropractic physiotherapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder ASAD/DCR evaluation of rotator cuff: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Surgery for rotator cuff repair.

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of rotator cuff repair. Within the medical information available for review, there is documentation of diagnoses of right shoulder bursitis and impingement, right symptomatic AC joint, and subscapularis tendon partial tear. In addition, there is documentation of subjective findings (pain with overhead movements and pain at night), objective findings (weak abduction, tenderness over anterior acromial area, and positive impingement sign), imaging findings (positive evidence of deficit in rotator cuff), and failure of 3-6 months of conservative treatment (medication, physical therapy, chiropractic treatment, and home exercise program). In addition, there is documentation that the patient refused cortisone injections. Therefore, based on guidelines and a review of the evidence, the request for Right Shoulder ASAD/DCR evaluation of rotator cuff is medically necessary.

12 visits of postoperative chiropractic therapy: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: MTUS Postsurgical Treatment Guidelines supports 24 visits over 14 weeks for the postoperative management of impingement syndrome. There is documentation of a pending surgery that is medically necessary and a plan indicating twelve visits of postoperative chiropractic physiotherapy. Therefore, based on guidelines and a review of the evidence, the request for 12 visits of postoperative chiropractic therapy is medically necessary.

Follow-up in 6 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visits.

Decision rationale: MTUS does not address this issue. ODG identifies that visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker and that the need for office visits is based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Within the medical information available for review, there is documentation of diagnoses of right shoulder bursitis and impingement, right symptomatic AC joint, and subscapularis tendon partial tear. In addition, given documentation of a pending surgery that is medically necessary, there is documentation that the patient is currently under the care of the provider and has a clinical condition necessitating a follow-up visit in order to monitor the patient's progress and make any necessary modifications to the treatment plan. Therefore, based on guidelines and a review of the evidence, the request for follow-up in 6 weeks is medically necessary.