MAXIMUS Federal Services

Case Number:	CM13-0057751		
Date Assigned:	06/09/2014	Date of Injury:	09/05/2012
Decision Date:	08/18/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	11/25/2013

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 Orthopedic Surgery. 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 injured worker is a 60-year-old female who reported an injury on 09/05/2012 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to the bilateral shoulders and right knee. The injured worker's treatment history included physical therapy, chiropractic care, medications, activity modification, aquatic therapy, and a TENS unit. The injured worker underwent an ultrasound of the bilateral shoulders on 01/24/2013 that documented there was a small full thickness tear of the left shoulder. The injured worker had persistent pain complaints. The injured worker was evaluated on 10/04/2013. Physical findings included significantly limited range of motion described as 90 degrees in forward flexion, 40 degrees in extension, 90 degrees in abduction, 40 degrees in adduction, 60 degrees in external rotation and 30 degrees in internal rotation with severe supraspinatus tenderness to palpation and severe acromioclavicular joint tenderness. The request was made for left shoulder arthroscopic evaluation with arthroscopic subacromial decompression and distal clavicle resection of the rotator cuff.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARTHROSCOPIC EVALUATION LEFT SHOULDER ARTHROSCOPIC SUBCROMIAL DECOMPRESSION, DISTAL CLAVICLE RESECTION AND ROTATOR CUFF REPAIR: 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): 209-212.

Decision rationale: The requested arthroscopic evaluation of the left shoulder and arthroscopic subacromial decompression and distal clavicle resection and rotator cuff repair is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommend surgical intervention for shoulder injuries when there are clear examination findings supported by pathology identified on an imaging study that have failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker has an extensive conservative treatment history. Additionally, the ultrasound provided of the left shoulder does indicate that there is a small full thickness tear that would benefit from surgical intervention. The injured worker has significantly limited range of motion and severe tenderness to palpation of the left shoulder. Therefore, surgical intervention would be indicated in this clinical situation. As such, the requested arthroscopic evaluation of the left shoulder arthroscopic subacromial decompression and distal clavicle resection and rotator cuff repair is medically necessary and appropriate.

PRE OP CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines, and http://circ.ahajournals.org/cgi/content/full/116/17/e418.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-Operative Testing (General).

Decision rationale: The requested preoperative clearance is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines recommend preoperative testing for patients who have comorbidities that could contribute to intraoperative or postoperative complications. The clinical documentation submitted for review does indicate that the injured worker is a candidate for arthroscopic ambulatory surgery; however, the clinical documentation fails to identify any significant comorbidities that would cause intraoperative or postoperative complications. As such, the requested preoperative clearance is not medically necessary or appropriate.

POST OPERATIVE PHYSICAL THERAPY 3 TIMES A WEEK FOR 4 WEEKS: Overturned

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

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

Decision rationale: The requested postoperative physical therapy 3 times a week for 4 weeks is medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker is a surgical candidate for subacromial decompression and rotator cuff repair. California Medical Treatment Utilization Schedule recommends up to 24 postoperative visits for this type of surgical intervention. California Medical Treatment Utilization Schedule does recommend an initial course of treatment equal to half the number of visits recommended. This would be 12 visits of physical therapy. Therefore, the requested postoperative physical therapy would be indicated in this clinical situation. As such, the requested postoperative physical therapy 3 times a week for 4 weeks is certified.

CONTINUOUS PASSIVE MOTION (CPM) DEVICE TIMES 45 DAYS: 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), Shoulder Chapter, Continuous Passive Motion (CPM).

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 Passive Motion (CPM).

Decision rationale: The requested continuous passive motion device times 45 days is not medically necessary or appropriate. Official Disability Guidelines do not support the use of continuous passive motion machines postsurgically for shoulder injuries. The clinical documentation submitted for review does not provide any exceptional factors to support extending treatment beyond guideline recommendations. As such, the requested continuous passive motion device times 45 days is not medically necessary or appropriate.

SURGI-STIM UNIT FOR INITIAL OF 90 DAYS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit, Post-operative pain Page(s): 116.

Decision rationale: The requested Surgi-Stim unit for initial use of 90 days is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the postsurgical use of a TENS unit for approximately 30 days to assist with postsurgical pain. The clinical documentation does indicate that the injured worker is a candidate for orthopedic ambulatory surgery of the left shoulder; however, the request exceeds the 30 day recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Surgi-Stim unit for initial use of 90 days is not medically necessary or appropriate.

COOLCARE COLD THERAPY UNIT: 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) Shoulder chapter, Continuous Flow Cryotherapy.

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: The requested CoolCare cold therapy unit is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines recommend up to 7 days of a continuous flow cryotherapy unit in the postsurgical management of a shoulder injury; however, the request does not specifically identify if this is for rental or purchase. Additionally, there is no documentation of a duration of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested CoolCare cold therapy unit is not medically necessary or appropriate.