

Case Number:	CM14-0001489		
Date Assigned:	01/15/2014	Date of Injury:	11/29/2012
Decision Date:	07/07/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	01/03/2014

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 Neurological 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:

This case involves a 47-year-old who sustained an injury on 11/29/2012. The claimant is a food service worker who had persistent pain in their entire left arm, which started after an injury that occurred on 9/1/2010. The arm was re-injured on 11/29/2012, which resulted in an increase in her pain due to opening and closing box doors many times. The utilization review in question is from 12/16/2013. The requested right shoulder arthroscopy, subacromial decompression, repair of rotator cuff and possible debridement and/or repair of the greater tuberosity fracture; postoperative sling; polar care unit; continuous passive motion (CPM) rental for 21 days; fiscal therapy three (3) times a week for four (4) weeks were not approved due to the lack of clinical documentation and shoulder range of motion. The most recent office visit dated 12/19/2013, indicated that the claimant continued to experience ongoing right shoulder pain despite conservative treatment and physical therapy. An examination showed weakness with external rotation and abduction at 3/5. Abduction is 60, flexion is 80, external rotation is 40 and internal rotation brings her thumb to L5. Provocative testing is difficult to perform due to the patient's pain, but there appeared to be positive impingement to empty can testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY, SUBACROMIAL DECOMPRESSION, REPAIR OF ROTATOR CUFF AND POSSIBLE DEBRIDEMENT AND/ OR REPAIR OF THE GREATER TUBEROSITY FRACTURE: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Occupational Medicine Practice Guidelines, and the Official Disability Guidelines (ODG), Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: The MTUS/ACOEM Guidelines support shoulder surgery and rotator cuff repair in patients that failed to have an increase range of motion and strength of the musculature around the shoulder after a three (3) month exercise program and with the existence of a surgical lesion. Given the claimant's failure to improve with conservative treatment and therapy, as well as the documentation of clear clinical and imaging evidence, surgical decompression and repair is warranted.

POSTOPERATIVE SLING: 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): 195-219. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The MTUS/ACOEM and Official Disability Guidelines recommend a sling after shoulder surgery, because they keep the arm in a position, which helps takes tension of the repaired tendon. Therefore, a sling is considered medically necessary.

POLAR CARE UNIT: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), On-line Treatment Guidelines for the shoulder (<http://www.odg-twc.com/odgtwc/shoulder.htm>).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): ODG -TWC: Shoulder (Acute & Chronic) (updated 04/25/14).

Decision rationale: The Official Disability Guidelines indicate that cryotherapy used in the postoperative setting has been proven to decrease pain, inflammation, swelling, and narcotic usage and is recommended as an option after surgery for up to seven (7) days. This request is considered medically necessary.

CONTINUOUS PASSIVE MOTION (CPM) RENTAL FOR TWENTY-ONE (21) 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), On-line Treatment Guidelines for the shoulder (<http://www.odg-twc.com/odgtwc/shoulder.htm>).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): ODG - TWC Shoulder (acute and chronic) updated 4/25/14.

Decision rationale: The Official Disability Guidelines indicate that continuous passive motion (CPM) is not recommended after shoulder surgery. With regard to adding continuous passive motion to postoperative physical therapy, no difference in function, pain, range of motion or strength has been proven. This request is not considered medically necessary.

PHYSICAL THERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS:

Overtured

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The Postsurgical Treatment Guidelines allow for twenty-four (24) physical medicine treatment visits over fourteen (14) weeks following arthroscopic shoulder surgery. Therefore, physical therapy three (3) times a week for four (4) weeks is considered medically necessary.