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| Case Number: | CM14-0010491 | | |
| Date Assigned: | 02/21/2014 | Date of Injury: | 04/14/2012 |
| Decision Date: | 07/18/2014 | UR Denial Date: | 12/31/2013 |
| Priority: | Standard | Application Received: | 01/27/2014 |

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 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 30-year-old male who has filed a claim for left shoulder impingement syndrome with superior labral tear from anterior to posterior (SLAP) tear associated with an industrial injury date of April 14, 2012. A review of progress notes indicates neck pain with bilateral arm pain in the C6 distribution, and left shoulder pain. Findings include decreased sensation and weakness along the C6 distribution, decreased range of motion of the shoulder, positive impingement signs, positive Speed's test, positive deAnquin's test, and tenderness along the bicipital groove. A cervical MRI dated November 11, 2013 showed disc protrusions at C5-6 and C6-7. Electrodiagnostic testing dated January 29, 2013 showed mild left ulnar neuropathy at the elbow. Mention of a left shoulder MRI from December 26, 2012 showed stage III impingement with underlying SLAP tear. The treatment to date has included NSAIDs, opioids, muscle relaxants, cervical traction, transcutaneous electrical nerve stimulation, cervical and lumbar epidural steroid injections, physical therapy, and corticosteroid injection to the left shoulder. The utilization review from December 31, 2013 denied the requests for arthroscopic subacromial decompression, distal clavicle excision, bursectomy, and rotator cuff repair as indicated with subpectoral tenodesis of the biceps versus SLAP repair of left shoulder; medical clearance; post-operative aquatic therapy for the left shoulder; and durable medical equipment including Polar Ice and Ultra sling. Reasons for denial were not indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARTHROSCOPIC SUBACROMIAL DECOMPRESSION, DISTAL CLAVICLE EXCISION, BURSECTOMY AND ROTATOR CUFF REPAIR AS INDICATED WITH SUBPECTORAL TENODESIS OF HIS BICEPS VERSUS SLAP REPAIR OF LEFT SHOULDER: 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 Non-MTUS Official Disability Guidelines (ODG) Shoulder chapter, Surgery for impingement syndrome.

Decision rationale: The California MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the ODG was used instead. The ODG criteria for arthroscopic decompression include 3-6 months of conservative care; pain with active arc motion at 90-130 degrees pain at night; weak or absent abduction or atrophy, tenderness over rotator cuff or anterior acromial area, and positive impingement sign with temporary relief with anesthetic injection; and positive imaging findings of impingement. In this case, there is no documentation regarding findings of pain upon active arc motion at 90-130 degrees, pain at night, atrophy, or weak/absent abduction. Also, the left shoulder MRI was not submitted with the documentation. Therefore, the request for arthroscopic subacromial decompression, distal clavicle excision, bursectomy, and rotator cuff repair as indicated with subpectoral tenodesis of the biceps versus SLAP repair of left shoulder was not medically necessary.

MEDICAL 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.

EIGHT VISITS OF POST-OPERATIVE AQUATIC THERAPY FOR THE LEFT SHOULDER: 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.

DURABLE MEDICAL EQUIPMENT POLAR ICE AND 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 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.