

Case Number:	CM14-0011522		
Date Assigned:	02/21/2014	Date of Injury:	09/15/2013
Decision Date:	07/15/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/29/2014

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 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:

According to the records made available for review, this is a 20-year-old female with a 9/15/13 date of injury. At the time (11/6/13) of the request for authorization for right shoulder arthroscopy subacromial decompression, pre op labs, and physical therapy post operation three times a week for four weeks. There is documentation of subjective right shoulder and arm constant severe pain, difficulty moving up and down with her arm and objective range of motion is markedly reduced, internal rotation up to L5, and abduction against resistance. The MRI of the right shoulder on 10/4/13 report revealed low-lying acromion with lateral downsloping. These may predispose to impingement syndrome. Mild subacromial subdeltoid bursitis. Tendinosis of the supraspinatus tendon. The patients current diagnoses are subacromial impingement syndrome and bursitis. The patients current treatment is activity modification. The patient has declined injection. There is no documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs.

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: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Disability Guidelines, Shoulder Chapter, Subacromial Decompression.

Decision rationale: The California 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. Official Disability Guidelines identifies documentation of conservative care as recommend 3 to 6 months; The subjective clinical findings would be pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases). The objective clinical findings would be 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). The imaging clinical findings would be 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 subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of subacromial impingement syndrome and bursitis. In addition, there is documentation of subjective clinical findings (right shoulder and arm constant severe pain, difficulty moving up and down with her arm), objective clinical findings (range of motion is markedly reduced, internal rotation up to L5, and abduction against resistance), imaging clinical findings (MRI showing positive evidence of deficit in rotator cuff), and the patient declined injection. However, there is no documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs. Therefore, based on guidelines and a review of the evidence, the request for a right shoulder arthroscopy subacromial decompression is not medically necessary.

PRE OP LABS: Upheld

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

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, Preoperative lab testing.

Decision rationale: The California MTUS does not address this issue. Official Disability Guidelines identifies that preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. Within the medical information available for review, there is documentation of diagnoses of subacromial impingement syndrome and bursitis. However, an associated request for surgery is not medically necessary. Therefore, based on guidelines and a review of the evidence, the request for pre op labs is not medically necessary.

PHYSICAL THERAPY POST OPERATION THREE TIMES A WEEK FOR FOUR WEEKS: Upheld

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 California MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, the California MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. The California MTUS-definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of subacromial impingement syndrome and bursitis. However, an associated request for surgery is not medically necessary. Therefore, based on guidelines and a review of the evidence, the request for physical therapy post operation three times a week for four weeks is not medically necessary.