

Case Number:	CM14-0011858		
Date Assigned:	02/21/2014	Date of Injury:	11/20/2007
Decision Date:	07/24/2014	UR Denial Date:	01/07/2014
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 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 50-year-old female who has submitted a claim for right shoulder impingement syndrome, cervical sprain / strain, lumbar disc protrusion, major depression, adjustment disorder with anxiety, systemic lupus erythematosus, fibromyalgia, hypertension, GERD, hyperlipidemia, and diabetes mellitus associated with an industrial injury date of 11/20/2007. Medical records from 2013 to 2014 were reviewed. Patient complained of right shoulder pain, graded 7/10 in severity. This resulted to difficulties with pushing, pulling, and overhead reaching. Blood pressure was measured at 153/79 mmHg, heart rate of 84 beats per minute and capillary blood glucose of 235 mg/dL. Cardiovascular exam was unremarkable. Epigastric tenderness was noted. Physical examination of the right shoulder showed restricted range of motion, tenderness, muscle guarding, and weakness graded 4/5. Impingement test and Cross-arm test were positive. MRI of the right shoulder, dated 09/25/2013, showed tendinosis and peritendinitis of the supraspinatus tendon with no rotator cuff tear identified. Fracture and dislocation were not evident. Acromioclavicular joint was intact. Electrocardiogram showed sinus bradycardia (unspecified date). Hemodynamic status report from 11/01/2013 showed systolic blood pressure at 145 mmHg, heart rate of 54 beats per minute, and cardiac output at 4.4. HbA1c was 6.4%, blood glucose was 108 mg/dL, ALT of 53 U/L, and AST of 73 U/L. Treatment to date has included physical therapy, extracorporeal shockwave therapy, subacromial cortisone injection, and medications such as Prozac, ibuprofen, lisinopril, Dexilant, Tricor, Crestor, metformin, Sentra AM, and Sentra PM. Previous utilization review was not made available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPIC EVALUATION, ARTHROSCOPIC SUBACROMIAL DECOMPRESSION, DISTAL CLAVICLE RESECTION, LABRAL AND/OR CUFF DEBRIDEMENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

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 Section, Diagnostic Arthroscopy, Surgery for Impingement Syndrome, Partial ClaviculectomyX Other Medical Treatment Guideline or Medical Evidence: Supraspinatus Tendonitis, <http://emedicine.medscape.com/article/93095-overview>.

Decision rationale: The California MTUS/ACOEM Practice Guidelines supports surgical intervention for patients who have: (1) red flag conditions; (2) activity limitation for more than four months, plus existence of a surgical lesion; (3) failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; (4) clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term, from surgical repair. Furthermore, the Official Disability Guidelines (ODG) states that a criterion for decompression should include imaging finding of impingement. In this case, the patient complained of persistent right shoulder pain despite conservative treatment involving physical therapy, extracorporeal shockwave therapy, subacromial cortisone injection, and intake of medications. This resulted to difficulties with pushing, pulling, and overhead reaching. Physical examination of the right shoulder showed restricted range of motion, tenderness, muscle guarding, and weakness. Impingement test and Cross-arm test were positive. Clinical manifestations were corroborated by MRI findings of tendinosis and peritendinitis of the supraspinatus tendon. Medscape cited that supraspinatus tendonitis is often associated with shoulder impingement syndrome. The medical necessity for arthroscopic subacromial decompression has been established. However, the present request also included distal clavicle resection. ODG states that partial claviculectomy should only be considered among cases with imaging findings of post-traumatic changes of AC joint, or severe DJD of AC joint, or complete or incomplete separation of AC joint. However, the MRI in this case showed intact acromioclavicular joint. The medical necessity for distal clavicle resection was not established. Therefore, the request for right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, distal clavicle resection, labral and/or cuff debridement is not medically necessary and appropriate.

STANDARD PRE OP 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.

Post operative physical therapy three times a week for four: 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.

CPM for 45 days: 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.

SURGI-STIM UNIT FOR 90 DAYS (PURCHASE OF UNIT RECOMMENDED WHEN IT PROVIDES CONTINUING FUNCTIONAL AND SYMPTOMATIC BENEFIT AT 90 DAYS USE): 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.

COOLCARE COLD THERAPY UNIT: 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.