

Case Number:	CM14-0137423		
Date Assigned:	09/05/2014	Date of Injury:	12/04/2013
Decision Date:	09/25/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/25/2014

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:

This 43-year-old female packer sustained an industrial injury on 12/4/13 relative to a trip and fall. Records indicated the patient was diagnosed with C5/6 disc herniation, cervical radiculitis, grade 1 retrolisthesis L5 over S1 with disc bulge and L5 radiculopathy, and left knee internal derangement. Records did not document a diagnosis relative to the left shoulder or evidence that a left shoulder MRI had been performed. There was no documentation of physical therapy to the left shoulder. The 7/8/14 treating physician report cited worsening and severe low back pain, neck pain, and continued knee, leg, hip, shoulder and arm pain. Excellent relief of left shoulder pain was reported with an injection, but symptoms have recurred. Left shoulder exam findings documented pectoralis and parascapular tenderness, positive Neer's and Hawkin's tests, positive acromioclavicular (AC) joint tenderness, positive AC joint compression test, positive crossover test, and 4/5 resisted abduction and external rotation strength. Left shoulder range of motion was forward flexion 170, abduction 170, internal rotation 60, and external rotation 80 degrees. The treatment plan requested authorization for a left shoulder arthroscopy with subacromial decompression and AC joint resection as she failed all conservative treatment including impingement test injection. The 7/22/14 utilization review denied the left shoulder surgery and associated requests as there was no imaging results documented and conservative treatment was not detailed. The 9/8/14 treating physician letter requested authorization for shoulder arthroscopy, subacromial decompression, and AC joint resection to avoid any further untoward effects.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy/SAD/AC joint resection: 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 rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are typically required. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive guideline-recommended conservative treatment had been tried and failed. There is no imaging evidence of impingement documented. Clinical exam findings do not document painful arc of motion or night pain. Therefore, this request is not medically necessary.

Post op physical therapy 3 x 6: 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: As the surgical request is not supported, this request is not medically necessary.

Vascutherm 4w/DVT cold compression x 21 days rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee and Leg Chapter and Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Venous Thrombosis.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.