

Case Number:	CM14-0179710		
Date Assigned:	11/04/2014	Date of Injury:	07/22/2010
Decision Date:	12/09/2014	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	10/29/2014

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 Georgia. 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 injured worker is a 41-year-old male who reported injuries due to a trip and fall on 07/22/2010. On 06/12/2014, his diagnoses included osteoarthritis of the bilateral knees, left ulnar nerve neuritis, and left carpal tunnel syndrome, bilateral shoulder impingement syndrome, musculoligamentous sprain/strain of the cervical spine with spondylosis, musculoligamentous strain of the lumbar spine, status post right and left knee arthroscopic surgeries on 08/28/2012 and 03/27/2012, and status post right carpal tunnel release and right ulnar nerve anterior transposition on 11/26/2013. His complaints included bilateral knee and left elbow and hand pain. On examination of his left shoulder, there were no gross abnormalities. There was tenderness over the greater tubercle and over the acromioclavicular joint. His left shoulder ranges of motion measured in degrees were limited to 145 degrees of abduction and forward flexion. There was a positive Neer's and cross arm sign with a painful arc of rotation. On 06/25/2014, he presented with pain in the left shoulder rated 10/10. There was significant tenderness over the greater tubercle, coracoid process, and acromioclavicular joint. His ranges of motion were limited to 90 degrees abduction and 85 forward flexion. On 08/07/2014, it was noted that an MRI of 01/24/2014 indicated moderate tendinosis with interstitial tearing at the junction of the superior and infraspinatus tendon of the left shoulder. Chronic degenerative changes of the posterior and superior labrum were also noted, along with moderate acromioclavicular joint arthrosis. The recommendation was for a left shoulder arthroscopic examination and decompression. There was further recommendation for medical clearance, ultrasling, cold therapy, and postoperative physical therapy. The rationale for the surgery was that he would not be able to reach maximum medical improvement level or find gainful employment until the surgery of the left shoulder was completed. There was no other rationale

included in this injured worker's chart. A Request for Authorization for the surgery and physical therapy only dated 10/02/2014 was included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic decompression and synovectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for impingement syndrome.

Decision rationale: The request for Left shoulder arthroscopic decompression and synovectomy is not medically necessary. The California ACOEM Guidelines note that surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, carried out for at least 3 months to 6 months before considering surgery. The Official Disability Guidelines go on to note that arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. A recent randomly controlled trial concluded that arthroscopic acromioplasty provides no clinically important effects over a structured and supervised exercise program alone in terms of subjective outcome or cost effectiveness when measured at 24 months, and that structured exercise treatment should be the basis for treatment of shoulder impingement syndrome, with operative treatment offered judiciously. It was noted in the submitted documentation that this injured worker had limitation in his ranges of motion and his activities of daily living. It also noted that he had conservative care, including physical therapy and non-steroidal anti-inflammatory medications, as well as 2 cortisone injections in the subacromial region, which have not yielded satisfactory outcome. There was no documentation of the extent of physical therapy, the number of treatments, the time frame, or the body parts treated. There was no evidence in the submitted documentation of previously failed treatment modalities with acupuncture and chiropractic. Furthermore, an independent imaging report was not provided to support the need for surgical intervention. The clinical information submitted failed to meet the evidence based guidelines for shoulder impingement surgery. Therefore, this request for Left shoulder arthroscopic decompression and synovectomy is not medically necessary.

Post op physical therapy QTY 12: 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.

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.

Ultrasling: 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.

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.

med shirt to help with posture: 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 Official Disability Guidelines (ODG), Knee & Leg, Durable medical equipment (DME).

Decision rationale: The request for med shirt to help with posture is not medically necessary. In the Official Disability Guidelines, durable medical equipment (DME) is recommended generally if there is a medical need and if the device or system meets Medicare's definition of DME, defined as equipment which can withstand repeated use, for example, could

normally be rented and used by successive patients, and is primarily and customarily used to serve a medical purpose. The treatment plan request for the [REDACTED] med shirt on 10/02/2014 noted a rationale of helping with this worker's posture. There was no clinical documentation of posture abnormalities. This requested shirt does not meet Medicare's guidelines for durable medical equipment. Therefore, this request for [REDACTED] med shirt to help with posture is not medically necessary.