

Case Number:	CM14-0182754		
Date Assigned:	11/07/2014	Date of Injury:	01/09/2012
Decision Date:	12/30/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	11/03/2014

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 is a 40 year old female with a 1/9/12 injury date. She sustained an injury due to a poor ergonomic work station, and repetitive trauma. She is currently not working. On 1/13/14, the patient underwent left shoulder arthroscopic subacromial decompression. In a 9/5/14 note, the patient complained of continued headaches, neck and upper back pain, and constant bilateral shoulder pain, as well as multiple other musculoskeletal complaints of pain. Objective findings included right shoulder tenderness to palpation over the anterior and lateral aspects of the joint, decreased shoulder flexion with pain, and positive impingement signs. There is a left shoulder MRI available from 6/21/12, but no right shoulder MRI. Diagnostic impression: myofascial pain syndrome, right shoulder impingement syndrome. Treatment to date: physical therapy for left shoulder, lower back, and neck; left shoulder cortisone injection; medications; left shoulder surgery. A UR decision on 10/7/14 denied the request for right shoulder arthroscopy with subacromial decompression because there was no documentation of a cortisone injection or MRI. In addition, the patient has diffuse myofascial pain syndrome and is at high risk for failure of surgical treatment. The requests for pre-op labs, physical therapy, cold therapy unit, and sling were denied because the associated surgical procedure was not certified.

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 Chapter 9 Shoulder Complaints Page(s): 211, Postsurgical Treatment Guidelines Page(s): 26-27. Decision based on Non-MTUS Citation ODG, Shoulder

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 Chapter--Surgery for impingement syndrome.

Decision rationale: CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. However, there is a lack of documentation of prior conservative treatment with respect to the right shoulder, including physical therapy and a subacromial cortisone injection. This is especially important in this patient given diffuse myofascial pain syndrome which mandates that surgery be approached with extreme caution and as a last resort. The patient continues to have constant bilateral shoulder pain even after undergoing surgical treatment for left shoulder impingement syndrome in January 2014. The chances of achieving a beneficial result by repeating the same surgery in the right shoulder would appear to be low at this point. In addition, there is no documentation or discussion of a right shoulder MRI. The medical necessity of the procedure has not been established at this time. Therefore, the request for right shoulder arthroscopic subacromial decompression is not medically necessary.

Pre-Op Labs: 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): Low Back Chapter--Pre operative EKG and Lab testing.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are 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: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

DME Rental-Cold Therapy Unit (days); Qty: 10: 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 and Leg Chapter--Continuous-flow cryotherapy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

DME- Shoulder Sling: 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): Shoulder Chapter--Immobilization.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.