MAXIMUS Federal Services

Case Number:	CM14-0034113		
Date Assigned:	06/20/2014	Date of Injury:	05/02/2008
Decision Date:	10/01/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	03/18/2014

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 47-year-old female bus driver sustained an industrial injury on 5/2/08. Injury occurred when she was going down the stairs to get off a bus, and a car ran into the back of the bus. She gripped the handrail to avoid falling off and felt a pulling sensation in her neck and right shoulder. Past medical history was positive for fibromyalgia. The cervical MRI dated 7/1/09 was positive for degenerative disc disease with minor disc bulging at C4/5 and C5/6. She is status post two right shoulder surgeries, including arthroscopic debridement and clavicle excision on 10/11/12. The 12/20/13 right shoulder MRI impression documented a delaminating interstitial tear of the supraspinatus footprint fibers. There was no full thickness retracted tear. There were postsurgical changes at the acromioclavicular joint and degenerative glenohumeral joint changes. There were subcortical cystic changes underneath the biceps anchor insertion. The 1/29/14 orthopedic surgeon report cited on-going and worsening right shoulder pain. X-rays were taken and showed more than 50% narrowing of the joint space. There were significant degenerative changes on the MRI. Physical exam documented relatively good range of motion at 70%. Exam was very painful. There was good strength but she broke easily, complaining of pain. The patient reported extremely limited use of the right arm because of pain. The treatment plan recommended simple arthroscopy for better evaluation of the joint, debridement, and assessment to determine whether she would then be a possible candidate for shoulder arthroplasty or simple resurfacing. The 2/19/14 utilization review denied the right shoulder surgery and associated requests as there was no documentation that guideline-recommended conservative treatment, including injections, had been attempted and failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment Integrated Treatment/Disability Duration Guidelines 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, Diagnostic arthroscopy

Decision rationale: The California MTUS state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been show to benefit, in the short and long-term, from surgical repair. In general, conservative treatment, including corticosteroid injections, is recommended to be carried out for at least 3 to 6 months before considering surgery. The Official Disability Guidelines state that diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. There is no evidence of therapeutic or diagnostic injection testing. Therefore, this request is not medically necessary.

12 sessions of Post-Operative Physical Therapy to treat the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Rotator Cuff Syndrome/Impingement Syndrome Page(s): 27.

Decision rationale: As the surgical request is not supported, the associated services are not medically necessary.

Polar Care Device: Upheld

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

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

Decision rationale: As the surgical request is not supported, the associated services are not medically necessary.

Sling: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213.

Decision rationale: As the surgical request is not supported, the associated services are not medically necessary.