

Case Number:	CM14-0056107		
Date Assigned:	07/09/2014	Date of Injury:	10/19/2006
Decision Date:	08/08/2014	UR Denial Date:	04/08/2014
Priority:	Standard	Application Received:	04/25/2014

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 51-year-old female sustained an industrial injury on 10/19/06. The mechanism of injury was not documented. She was status post bilateral carpal tunnel releases in 2010, right shoulder manipulation under anesthesia on 3/11/08, and right first dorsal compartment release and right ulnar nerve release on 10/30/07. The patient was using a cervical spinal cord stimulator for a diagnosis of bilateral upper extremity complex regional pain syndrome Type 1. The 3/31/14 treating physician report cited debilitating left shoulder pain. Pain was aggravated by reaching, lifting above shoulder level, pushing and pulling. Associated symptoms included sleep disturbance, weakness, stiffness, numbness and tingling. Pain was relieved by medications. Left shoulder physical exam documented anterior shoulder tenderness including the subacromial space and acromioclavicular joint. There was painful arc of motion, 5/5 deltoid strength, positive Neer and Hawkins's impingement tests, and positive cross chest, AC joint compression, O'Brien's, Speed's, and dynamic compression shear tests. The diagnosis was impingement syndrome. The treatment plan recommended left shoulder arthroscopic acromioplasty with distal claviclectomy with possible biceps tenodesis. A left subacromial injection was provided with a 50% reduction in pain. The 4/8/14 utilization review did not grant the request for left shoulder surgery and associated durable medical equipment as there was no documentation of recent conservative treatment, current range of motion, and recent imaging to support the medical necessity. The 5/12/14 treating physician report cited debilitating shoulder pain and significant limitation in overall function. The patient failed to respond to conservative measures, including 2 visits of physical therapy. The surgical denial was appealed and a left shoulder CT arthrogram was recommended. The 6/13/14 CT arthrogram impression documented a Type II acromion with mild acromioclavicular osteoarthritis with no definite evidence for rotator cuff tear. The 6/18/14 diagnostic injection test resulted in 80% improvement in pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic acromioplasty with distal claviclectomy with possible biceps tenodesis: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 209-212. Decision based on Non-MTUS Citation Official Disability Guidelines- Shoulder (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty, Partial claviclectomy, Surgery for ruptured biceps tendon.

Decision rationale: The California MTUS guidelines do not address shoulder surgeries for chronic injuries. The Official Disability Guidelines for acromioplasty require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. The Official Disability Guidelines state that consideration of biceps tenodesis should include evidence of an incomplete tear with associated subjective/objective clinical findings. Guideline criteria have been met. This patient has significant pain and marked functional limitations with exam findings and diagnostic injection test positive for impingement. She had failed at least 3-6 months of reasonable conservative treatment including activity modification, medications, physical therapy, and injection. Therefore, this request for left shoulder arthroscopic acromioplasty with distal claviclectomy with possible biceps tenodesis is medically necessary.

CPM rental x 21 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Shoulder (Acute & Chronic).

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 passive motion (CPM).

Decision rationale: The California MTUS does not provide recommendations for this device in chronic shoulder conditions. The Official Disability Guidelines state that continuous passive motion (CPM) is not recommended for shoulder rotator cuff problems or after shoulder surgery, except in cases of adhesive capsulitis. Guideline criteria have not been met. There is no evidence of adhesive capsulitis to support the medical necessity of this request. Therefore, this request for CPM rental x 21 days is not medically necessary.

Cold therapy purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Shoulder (Acute & Chronic).

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: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following shoulder surgery. Under consideration is a request for purchase of a cold therapy unit. Although the use of cold therapy during the post-operative period would be appropriate for this patient, there is no compelling reason to support the medical necessity of this request beyond the 7-day guideline recommendation. Therefore, this request for cold therapy purchase is not medically necessary.