

Case Number:	CM14-0090216		
Date Assigned:	07/23/2014	Date of Injury:	09/18/2008
Decision Date:	10/01/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/16/2014

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 Texas. 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 46-year-old female who reported an injury on 12/02/2009. The mechanism of injury was not provided for clinical review. The diagnoses included right shoulder impingement syndrome, status post bilateral shoulder injuries, supraspinatus rotator cuff tendonitis, and impingement of the right shoulder. Previous treatments included physical therapy and medication. Diagnostic testing included an MRI of the right shoulder on 03/01/2014. Within the clinical note dated 05/05/2014, it was reported the injured worker complained of contralateral right shoulder pain. She rated her pain 8/10 in severity. Upon the physical examination of the shoulder, the provider noted the range of motion was forward flexion of the right shoulder 145 degrees and extension at 40 degrees. The injured worker had tenderness to palpation of the supraspinatus, greater tuberosity. The injured worker had AC (acromioclavicular) joint tenderness. The provider noted the injured worker had subacromial crepitus. The provider noted the injured worker distal sensation normal to light touch on the right. The injured worker had a positive AC joint compression test and impingement test. The MRI scan dated 03/01/2014 revealed a supraspinatus rotator cuff tendonitis and impingement. However, no rotator cuff or labral tear was noted. The provider requested an arthroscopic right shoulder evaluation, arthroscopic subacromial decompression, distal clavicle resection, and labral and rotator cuff debridement; continuous passive motion device; Surgi Stim unit; and [REDACTED] cold therapy. However, a rationale was not provided for clinical review. The Request for Authorization was submitted and dated 05/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic right shoulder evaluation, arthroscopic subacromial decompression, distal clavicle resection and labral and rotator cuff debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): www.odg-twc.com Section: Shoulder (Acute and Chronic) (updated 04/25/2014)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: The request for an arthroscopic right shoulder evaluation, arthroscopic subacromial decompression, distal clavicle resection and labral and rotator cuff debridement is not medically necessary. The California MTUS/ACOEM Guidelines state that consultation is intended to aid in assessing the diagnosis, prognosis, and therapeutic management, determination of medical stability, and pertinent residual loss and/or the examinee's fitness to return to work. The guidelines also note patients with AC joint separation may be treated conservatively. The expected pain period is 3 weeks, with pain gradually decreasing. If pain persists after recover and return to activities, resection of the outer clavicle may be indicated after 6 months to 1 year, although local cortisone injections can be tried. Rotator cuff repair is indicated for significant tears that impair activity by causing of arm elevation or rotation, particular acutely in younger workers. Rotator cuff tears are frequently partial thickness or smaller thickness tears. For partial thickness rotator cuff tears and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The preferred procedure is usually an arthroscopic decompression, which involves debridement of inflamed tissues, burning of the anterior acromion, and lysis and sometimes removal of the coracoacromial ligament, and possibly removal of the outer clavicle. Surgery is not indicated in patients with mild symptoms and those whose activities are not limited. There is a lack of significant documentation of the official MRI indicating the injured worker had a significant tear that impairs activity by causing weakness of the arm elevation or rotation. The clinical documentation submitted by the provider indicated the injured worker failed conservative therapy. However, there is a lack of clinical documentation indicating the injured worker had undergone an adequate trial of 3 months of conservative therapy. There is a lack of imaging studies to corroborate the findings of a rotator cuff tear. The request for a consultation is also not medically necessary. Therefore, the request is not medically necessary.

Home Continuous Passive Motion device x 45 days: 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.

Surgi-Stim unit x 90 days: 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 X 90 days: 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.