MAXIMUS Federal Services

Case Number:	CM14-0097403		
Date Assigned:	09/23/2014	Date of Injury:	04/24/2014
Decision Date:	12/15/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	06/25/2014

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 is a 56 year old female with a 4/24/13 injury date. In a 6/9/14 follow-up, the patient returned to working regular duties and continues to complain of neck and right shoulder pain. She had a right shoulder bursal cortisone injection on 5/14/14 which was helpful for 2 days until the pain returned to its original level. All activities and movements increase her shoulder pain. Objective findings included tenderness over the subacromial bursa, acromioclavicular joint, and biceps tendon. There was limited range of motion, positive impingement signs, positive Speed's test, negative Jobe's, and negative cross-body adduction test. A right shoulder MRI on 10/2/13 showed a partial tear of supraspinatus and subscapularis tendons, and mild low grade acromioclavicular (AC) joint arthrosis. In a 1/8/14 follow-up, the patient has a low thyroid condition and takes Synthroid. Her right shoulder range of motion was very limited, showing 90 degrees of abduction and 120 degrees of forward flexion. Diagnostic impression: right shoulder impingement syndrome. Treatment to date: Physical Therapy, Acupuncture, Cortisone Injection, Medications, Activity Modification. A UR decision on 6/25/14 denied the requests for right shoulder arthroscopic subacromial decompression with debridement and possible arthroscopic vs. open rotator cuff repair because the objective testing fails to report a surgical lesion and impingement is no mentioned in the MRI report. The requests for medical clearance, cold therapy unit, indwelling pain catheter, sling, and physical therapy were denied because the associated surgical procedures were not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION WITH DEBRIDEMENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

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--adhesive capsulitis (frozen shoulder)

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, in this case the diagnosis of impingement syndrome is not clear. The patient has "very limited" range of motion on exam, has a history of a thyroid condition, and takes Synthroid. In addition, she is a female in her 50's. Taken together, these findings raise concern for the diagnosis of frozen shoulder, in which case a subacromial decompression would not be appropriate. Impingement syndrome is usually not associated with reduced shoulder range of motion. In addition, the MRI in frozen shoulder usually does not point to specific capsular pathology, which is the case in this patient. Therefore, the request for right shoulder arthroscopic subacromial decompression with debridement is not medically necessary.

POSSIBLE ARTHROSCOPIC VS. OPEN ROTATOR CUFF REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

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, Rotator cuff repair

Decision rationale: CA MTUS states that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation; conservative treatment of full thickness rotator cuff tears has results similar to surgical treatment, but without the surgical risks, and further indicate that surgical outcomes are not as favorable in older patients with degenerative changes about the rotator cuff. In addition, ODG criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. However, in this case there is no evidence of a full-thickness tear on the imaging studies. Therefore, the request for possible arthroscopic vs. open rotator cuff repair is not medically necessary.

PRE OP MEDICAL CLEARANCE WITH INTERNIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery

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

COLD THERAPY UNIT (X7DAYS): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM CHAPTERS 8-14

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

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

PAIN BUSTER INDWELLING CATHETER (X72 HOURS): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

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--Postoperative pain pump

Decision rationale: Since the primary procedures are not medically necessary, none of the associated services are 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 (ODG)

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 procedures are not medically necessary, none of the associated services are medically necessary.

POST OPERATIVE PT (X24): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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