

Case Number:	CM14-0008169		
Date Assigned:	02/21/2014	Date of Injury:	04/10/2012
Decision Date:	04/01/2015	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/19/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 47-year-old female patient who sustained an industrial injury on 04/10/12. Injury occurred when her chair slipped out from under her and she fell to the ground, landing on her buttocks. The 10/10/13 orthopedic report cited continued bilateral shoulder pain with popping and grinding, painful arc above shoulder level, and symptoms of weakness. Diagnostic ultrasound performed on 4/17/13 revealed bilateral supraspinatus tendinitis and right sided subacromial/subdeltoid bursitis and right long head biceps tendinosis. A right shoulder corticosteroid injection on 7/23/13 provided two to three weeks of relief. Conservative treatment had included chiropractic services and aquatic therapy with only temporary relief. Physical exam documented tenderness over the subacromial and supraspinatus tendons bilaterally, tenderness over the right biceps tendon, and decreased bilateral shoulder range of motion with pain above 90 degrees of flexion and abduction bilaterally. Impingement and cross arm tests were positive bilaterally. Surgical consultation was recommended. The 12/16/13 treating physician report was handwritten and partially illegible. Subjective complaints documented unchanged bilateral shoulder pain. Physical exam documented limited shoulder flexion and abduction bilaterally. The diagnoses included: bilateral shoulder strain impingement as well as rotator cuff tear, tendonitis, bursitis and tenosynovitis; cervical strain with myofascial pain syndrome; thoracolumbar sprain 1-2 mm disc bulge L4-S1 stenosis; bilateral knee sprain; right ankle sprain calcaneal spur, plantar fasciitis; and right wrist sprain deQuervain's tenosynovitis. She had been using Tylenol #4, Fexmid and Voltaren gel for pain. A request was made for the following services; one left shoulder arthroscopic debridement and or decompression; medical clearance; 12 physical therapy

post-operative sessions left shoulder; 45 day rental continuous passive motion unit; 90 day rental surgical stimulation unit and one cold care therapy unit. On 1/16/14, utilization review non-certified the requests, noting the ACOEM Guidelines, Chapter 9, Shoulder complaints, and the ODG Acromioplasty were cited. The injured worker submitted an application for independent medical review of requested services.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 LEFT SHOULDER ARTHROSCOPIC DEBRIDEMENT AND/OR DECOMPRESSION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Conventional x-rays, AP, and true lateral or axillary view. AND MRI, ultrasound, or arthrogram showing positive evidence of impingement are required. Guideline criteria have not been met. This patient presents with bilateral shoulder pain, with popping and clicking. Clinical exam findings were consistent with bilateral shoulder impingement. Imaging was limited to diagnostic ultrasound on 4/17/13 that did not specifically document left shoulder impingement. There was evidence of rotator cuff and biceps tendinosis. There was no evidence of x-ray or MRI findings with evidence of impingement. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial directed to the shoulder and failure has been submitted. Therefore, this request is not medically necessary.

1 MEDICAL CLEARANCE WITH SPECIALIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation SURGERY GENERAL INFORMATION AND GROUND RULES, CALIFORNIA OFFICIAL MEDICAL FEE SCHEDULE, 1999 EDITION, PAGES 92-93.

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.

12 PHYSICAL THERAPY SESSIONS POST-OP LEFT SHOULDER: 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.

45 DAYS RENTAL OF CONTINUOUS PASSIVE MOTION (CPM) 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, 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

90 DAYS RENTAL OF SURGI-STIM UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

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

1 COOLCARE COLD THERAPY UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9 (SHOULDER COMPLAINTS) (2004), 203.

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