

<b>Case Number:</b>	CM14-0194750		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	11/06/2009
<b>Decision Date:</b>	01/16/2015	<b>UR Denial Date:</b>	11/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2014

### 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 Surgeon of the Hand and is licensed to practice in Hawaii, Washington, and Maryland. 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 65-year-old female who reported an injury on 11/06/2009. The mechanism of injury was not provided. The diagnoses included left shoulder impingement and painful hardware to the left wrist. Prior treatments included a corticosteroid injection and medication. Medications included Norco. No official diagnostics were provided. Objective findings dated 09/15/2014 revealed a positive impingement sign on the left shoulder with mild limitation of motion due to pain. There was tenderness to palpation over the volar aspect of the wrist when palpating the hardware and she was noted for discomfort. The treatment plan included 12 physical therapy sessions, removal of hardware to the left wrist, and a left shoulder arthroscopy and decompression. The Request for Authorization was not submitted within the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **12 Physical Therapy Sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical/Occupational therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical/Occupational therapy Official Disability Guidelines, Forearms, Wrist, & Hand (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The request for 12 physical therapy sessions is not medically necessary. The California MTUS state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend up to 10 physical therapy visits for up to 4 weeks. The documentation was unclear if this was the initial physical therapy or additional physical therapy. The injured worker already had been approved for 6 initial visits of physical therapy; however, the documentation was not provided. Therefore, the request for 12 visits of physical therapy is not medically necessary.

**1 removal of hardware in the left wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearms, Wrist, & Hand (Acute & Chronic) Impingement Syndrome

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand, Hardware implant removal (fracture fixation)

**Decision rationale:** The decision for 1 removal of hardware of the left wrist is not medically necessary. The Official Disability Guidelines indicate that hardware implant removal is not recommended for routine removal of hardware implanted for fracture fixation, except in cases of broken hardware or persistent pain after ruling out other causes of pain such as infection and nonunion. It is not recommended solely to protect against allergy, carcinogenesis, or metal detection. The documentation did not provide a functional pain scale. The documentation did not provide any diagnostics and there were no objective findings to warrant the need for a hardware removal. Additionally, the injured worker had received corticosteroid injections that were documented to be effective in pain control. Therefore, the request is not medically necessary.

**1 Left shoulder Arthroscopy and Decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic) (ODG) Indication of Surgery- Acromioplasty

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**Decision rationale:** The request for 1 left arthroscopy and decompression is not medically necessary. The California MTUS/ACOEM indicate that red-flag conditions. Activity limitation for more than four months, plus existence of a surgical lesion. Failure to increase ROM and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion. Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. Surgical considerations depend on the working or imaging-confirmed diagnosis of the presenting shoulder complaint. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and expectations, in particular, is very important. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may help resolve the symptoms. Surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least three to six months before considering surgery. Because this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendinitis, also refer to the previous discussion of rotator cuff tears. A review of the documentation was not evident that the injured worker had relief with her cortisone injections that lasted up to several months. The objective findings were vague or limited in the documentation. There was no diagnostic evidence to confirm the diagnosis or support the need for surgical intervention. Therefore, the request is not medically necessary.