

Case Number:	CM14-0198894		
Date Assigned:	12/09/2014	Date of Injury:	03/09/2012
Decision Date:	01/22/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	11/26/2014

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:

According to the records made available for review, this is a 45-year-old female with a 3/9/12 date of injury, and status post right shoulder impingement repair x 2. At the time (11/12/14) of request for authorization for surgery - open distal clavicle resection, Percocet, PT, shoulder kit, Ultra Sling III, Polar op appointment, and 2-3 post op appointment, there is documentation of subjective (right shoulder pain interfering with activities of daily living, pain aggravated with lifting, reaching, lying in bed, twisting and bending) and objective (right shoulder acromioclavicular tenderness, positive crossed body loading, mild impingement sign, some pain with resistance to abduction) findings, imaging findings (right shoulder MRI (5/10/13) report revealed mild tendinopathy of the supraspinatus, infraspinatus, and subscapularis tendons, mild fraying along the bursal side of the supraspinatus tendon, slight improvement in comparison to the prior study, acromioclavicular joint imprints on the supraspinatus muscle, query impingement symptoms), current diagnoses (right shoulder rotator cuff syndrome), and treatment to date (medications and acromioclavicular steroid injection). 10/19/14 medical report identifies the patient seems to have ongoing pain in the right shoulder secondary to acromioclavicular joint arthrosis, and a recommendation for surgery to assess the right shoulder and possibly perform subacromial decompression as needed as well as open distal clavicle resection and acromioclavicular debridement. 11/12/14 medical determination identifies request is for postoperative physical therapy 2 times a week for 4 weeks and Percocet #50. Regarding the requested shoulder kit, there is no documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. Regarding the requested Polar op appointment, there is no documentation of time-limited treatment plan.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery - Open Distal Clavicle Resection; Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder

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, Subacromial Decompression

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnosis of right shoulder rotator cuff syndrome. In addition, there is documentation of a recommendation for surgery to assess the right shoulder and possibly perform subacromial decompression as needed as well as open distal clavicle resection and acromioclavicular debridement; conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; objective clinical findings: tenderness over acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); and imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. Therefore, based on guidelines and a review of the evidence, the request for surgery - open distal clavicle resection is medically necessary.

Percocet: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, the associated services are not medically necessary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48.

Decision rationale: MTUS reference to ACOEM identifies documentation of severe pain, as criteria necessary to support the medical necessity of opioid therapy for a short period of time.

Within the medical information available for review, there is documentation of diagnosis of right shoulder rotator cuff syndrome. In addition, there is documentation of a pending surgery that is medically necessary. Furthermore, there is documentation of a request for Percocet #50. Therefore, based on guidelines and a review of the evidence, the request for Percocet is medically necessary.

PT: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, the associated services are not medically necessary.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS Postsurgical Treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnosis of right shoulder rotator cuff syndrome. In addition, there is documentation of a pending surgery that is medically necessary. Furthermore, there is documentation of a request for postoperative physical therapy 2 times a week for 4 weeks. Therefore, based on guidelines and a review of the evidence, the request for PT is medically necessary.

Shoulder kit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, the associated services are not medically necessary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Exercise and Knee & Leg, Home Exercise Kit

Decision rationale: MTUS does not address the issue. ODG identifies that there is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise; that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen; that a therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated; and that such programs should emphasize education, independence, and the importance of an on-going exercise regime. In addition, ODG identifies a home exercise kit is recommended as an option where home exercise programs are

recommended; that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. Within the medical information available for review, there is documentation of diagnosis of right shoulder rotator cuff syndrome. In addition, there is documentation that a home exercise program is recommended. However, there is no documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. Therefore, based on guidelines and a review of the evidence, the request for shoulder kit is not medically necessary.

Ultra Sling III: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, the associated services are not medically necessary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 44-45.

Decision rationale: MTUS reference to ACOEM guidelines identifies that a sling is recommended in the management of severe cases of biceps tendinosis with gentle range-of-motion exercises of the elbow, but evidence is insufficient or irreconcilable for the shoulder and wrist. Therefore, based on guidelines and a review of the evidence, the request for Ultra Sling III is not medically necessary.

Polar Op Appointment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, the associated services are not medically necessary.

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, Continuous-flow cryotherapy

Decision rationale: MTUS does not address this issue. ODG identifies continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. Within the medical information available for review, there is documentation of diagnosis of right shoulder rotator cuff syndrome. In addition, there is documentation of a pending surgery that is medically necessary. However, there is no documentation of a time-limited treatment plan. Therefore, based on guidelines and a review of the evidence, the request for Polar Op Appointment is not medically necessary.

2-3 Post Op Appointment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, the associated services are not medically necessary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations and consultations, page 127

Decision rationale: MTUS reference to ACOEM guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. Within the medical information available for review, there is documentation of diagnosis of right shoulder rotator cuff syndrome. In addition, there is documentation of a pending surgery that is medically necessary. However, there is no documentation of a rationale identifying a 2-3 post op appointments. Therefore, based on guidelines and a review of the evidence, the request for 2-3 Post Op Appointment is not medically necessary.