

Case Number:	CM14-0208958		
Date Assigned:	12/22/2014	Date of Injury:	04/04/2013
Decision Date:	02/20/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/15/2014

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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 67-year-old male who reported an injury on 04/04/2013. The mechanism of injury was not provided. He was diagnosed with carpal tunnel syndrome. His past treatments were noted to include chiropractic treatment, physical therapy, medications, and shockwave therapy. His diagnostic studies included an official MRI performed on 02/03/2014 of the right upper extremity, which was noted to reveal a low grade partial thickness intrasubstance tear of the infraspinatus tendon at the footprint and a very low grade partial thickness articular side tear at the junction of the posterior supraspinatus and inferior infraspinatus tendon at the footprint on a background of moderate tendinosis, mild subacromial bursal fluid, and moderate acromioclavicular joint osteoarthritis. On 11/04/2014, the injured worker reported right shoulder pain rated 9/10 and right wrist pain 8/10. No objective findings were provided. It was noted the injured worker had 17 physical therapy sessions and 12 chiropractic sessions with only mild improvement. His current medications were noted to include naproxen 550 mg twice a day. The treatment plan included medications as needed. A request was submitted for right shoulder arthroscopic subacromial decompression, postoperative physical therapy for the right wrist (3x3), and postoperative physical therapy for the right shoulder (3x); however, the rationale was not provided. A Request for Authorization was not submitted.

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: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 10/31/2014), Surgery for Impingement Syndrome, Acromioplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 10/31/2014), Surgery for Impingement Syndrome, Acromioplasty.

Decision rationale: The California MTUS/ACOEM Guidelines state surgery for impingement syndrome is usually arthroscopic decompression. More specifically, the Official Disability Guidelines recommend acromioplasty for acromial impingement after at least 3 to 6 months of conservative care and it is not recommended in conjunction with full thickness rotator cuff repair. The guidelines state criteria should include: conservative care for at least 3 to 6 months; subjective clinical findings of pain with active range of motion and pain at night; objective clinical findings of weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and a positive impingement sign; and imaging clinical findings. The clinical documentation submitted for review did not provide a physical examination. The clinical documentation does not indicate that the injured worker had pain with range of motion and does not indicate if pain occurred at night. The clinical documentation indicates that the injured worker had 17 physical therapy visits; however, it does not specify to what body part. Furthermore, the clinical documentation does not provide evidence of a positive impingement sign or indicate weak or absent abduction. Given the above information, the request is not supported by the guidelines. As such, the request for Right Shoulder Arthroscopic Subacromial Decompression is not medically necessary.

Associated Surgical Services: Post-Operative Physical Therapy for the Right Wrist (3 x 3): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The California MTUS Guidelines recommend active therapy for restoring flexibility, strength, endurance, function, range of motion, and alleviating discomfort. For carpal tunnel release, the guidelines recommend 3 to 8 visits over 3 to 5 weeks. The clinical documentation submitted for review indicates that the injured worker has had 17 physical therapy visits; however, it does not specify the specific body part. Therefore, it is unclear the number of physical therapy visits the injured worker has completed for the wrist. Additionally, it is unclear if the injured worker has had significant objective functional improvement with the prior physical therapy visits. Additionally, there are no exceptional factors to warrant additional

visits beyond the guideline recommendations. As such, the request for Associated Surgical Services: Post-Operative Physical Therapy for the Right Wrist (3 x 3) is not medically necessary.

Associated Surgical Services: Post-Operative Physical Therapy for the Right Shoulder (3x3): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

Decision rationale: As the injured worker does not qualify for the right shoulder arthroscopic subacromial decompression, the request is not supported by the guidelines. As such, the request for Associated Surgical Services: Post-Operative Physical Therapy for the Right Shoulder (3 x 3) is not medically necessary.