

Case Number:	CM15-0008553		
Date Assigned:	01/26/2015	Date of Injury:	03/22/2012
Decision Date:	03/30/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/15/2015

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: New York
 Certification(s)/Specialty: Neurological 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:

This 56 year old female cardiac monitor technician was lifting a heavy patient chart and experienced onset of pain in her neck and shoulder on 3/22/2012. The injured worker had complaints of neck and right shoulder pain. Physical examination findings revealed right shoulder restricted range of motion. Tenderness upon palpation of the acromioclavicular joint was noted. Neer sign and Hawkin's signs were positive. A MRI of the right shoulder was noted to have revealed impingement syndrome with rotator cuff tendinitis. Diagnoses included cervical spine disc protrusion at C5-6, cervical spine right sided C6 radiculopathy, cervical spine severe spinal stenosis, right shoulder impingement syndrome, and right shoulder rotator cuff tendonitis. She underwent and arthroscopic subacromial decompression as well as a labrum debridement and a right carpal tunnel release. MRI scan of the cervical spine showed a 3 mm disc protusion at C5-6. The treating physician requested authorization for right shoulder open subacromial decompression and 12 post-operative physical therapy sessions 3x4. The physician also requested associated surgical services of cold therapy unit for 21 days rental, CPM machine for 21 days rental, Knapp sling, and MSIR 30mg #90. On 12/31/14 the requests were non-certified. Regarding the right shoulder open subacromial decompression, the utilization review (UR) physician cited the Medical Treatment Utilization Schedule and the Official Disability Guidelines. The UR physician noted there was limited documentation of conservative measures attempted and failed to date. The surgery was non-certified therefore the associated services were also non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder open subacromial decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 214, table 9-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC, Shoulder Procedure Summary and Indication for Surgery-Acromioplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Shoulder chapter, surgery for impingement syndrome-criteria for acromioplasty

Decision rationale: The California MTUS guidelines note that an arthroscopic decompression is the usual surgery for an impingement syndrome. The provider has requested an open operation and has not included a rationale for this choice. Guidelines further note that the procedure is not indicated for patients with mild symptoms. This patient has progressively improved her range of motion indicating that she is responding to conservative care. Moreover, the ODG guidelines indicate that positive evidence of impingement should be shown on the MRI scan. The scan report of 12/02/2014 does not provide this evidence. Thus the requested treatment: Right shoulder open subacromial decompression is not medically necessary and appropriate.

12 Post-Op Physical Therapy sessions 3x4: 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.

Associated surgical service: Cold therapy unit for 21 days rental: 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.

Associated surgical service: CPM machine for 21 days rental: 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.

Associated surgical service: Knapp sling: 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.

MSIR 30mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines-Oral morphine. Opioids, steps to avoid misuse/addiction.

Decision rationale: The California MTUS guidelines do not recommend oral morphine as a primary treatment for persistent pain. Documentation does not show that this medication which has significant side effects is part of a monitored treatment program. The guidelines list steps to avoid misuse/addiction. The requested treatment does not show listing of any of these steps. Moreover, the guidelines do not recommend opioids as a first-line therapy for osteoarthritis. Thus the requested treatment MSIR 30mg#90 is not medically necessary and appropriate.