MAXIMUS Federal Services

Case Number:	CM15-0019695		
Date Assigned:	02/09/2015	Date of Injury:	07/23/2012
Decision Date:	04/03/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	02/02/2015

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: 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 50-year-old female who reported injury on 07/23/2012. The mechanism of injury was repetitive heavy lifting and carrying and repetitive upper extremity function. The injured worker was noted to be status post right carpal tunnel release and right ulnar nerve decompression at Guyon's canal on 04/23/2014. The injured worker was noted to undergo 3 steroid injections into the shoulder. The injured worker underwent an MRI of the left shoulder on 03/10/2014 which revealed mild lateral downsloping of the acromion with no evidence of rotator cuff tear. There was minimal subdeltoid effusion. There was a Request for Authorization submitted for review dated 02/11/2015. The documentation of 01/07/2015 indicated the injured worker had undergone extensive conservative treatment including the passage of time, the use of medications, physical therapy, chiropractic therapy, and multiple cortisone injections in the left shoulder. The physician further documented the injured worker's symptoms, physical examination, and diagnostic studies supported evidence of impingement. On physical examination, the injured worker had significantly limited range of motion with guarding, painful arc and tenderness over the rotator cuff and AC joint. The injured worker had pain with impingement maneuvers. The diagnostic studies included radiographs which demonstrated type II acromion with calcific tendonitis. The injured worker underwent an MRI of the left shoulder and the physician indicated upon his review of the MRI, there was clear evidence of rotator cuff tendinopathy with narrowing of the distal coraoacromial arch. The physician further documented the injured worker had failed conservative treatment related to the left shoulder and the injured worker should be reconsidered for a subacromial decompression and postoperative physical

therapy initially 12 visits, with cold therapy rental for 7 days. However, the physician indicated there would not be a need for the abduction pillow as there was no significant rotator cuff on the MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy subacromial decompression: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment for Workers' Compensation, Online Edition, Chapter Shoulder, Diagnostic Arthroscopy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: The American College of Occupational and Environmental Medicine indicate that a surgical consultation may be appropriate for an injured worker with activity limitation for more than 4 months, failure to increase range of motion and strength of the musculature around the shoulder even after exercise and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. Additionally, surgery for impingement syndrome is usually arthroscopic decompression and it is indicated for injured workers who fail conservative care including cortisone injections for 3 to 6 months. It is not recommended for injured workers with mild symptoms or those who have no activity limitations. The clinical documentation submitted for review indicated the injured worker had diagnostic studies including radiographs which demonstrated a type II acromion with calcific tendonitis. The injured worker had pain with impingement maneuvers, painful arc and tenderness over the rotator cuff, and had failed conservative care. While there was a lack of documentation of specific activity limitations, the injured worker had a painful range of motion and a painful arc. The injured worker had tenderness over the rotator cuff and AC joint. These were exceptional factors. The injured worker was 2 years post injury. There was no significant improvement with the injections and conservative care. Given the above, the request for left shoulder arthroscopy subacromial decompression is medically necessary.

Associated Surgical Services: Post-op physical therapy 3xwk x 4wks for left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints,Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California Postsurgical Treatment Guidelines recommend 24 sessions of physical therapy for impingement syndrome and the initial quantity of sessions should be half the recommended number, which would be 12. The surgical intervention was found to be

medically necessary. As such, the request for associated surgical services postoperative physical therapy 3 x Wk x 4 Wks left shoulder is medically necessary.

Associated Surgical Services: Cold therapy unit x7 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous flow cryotherapy.

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: The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended postoperatively for 7 days. This request would be supported as the surgical intervention is supported. However, the request as submitted failed to indicate the body part to be treated with the cold therapy unit. Given the above, the request for associated surgical services cold therapy unit x7 days is not medically necessary.

Associated Surgical Services: Abduction pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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, Postoperative abduction pillow sling.

Decision rationale: The Official Disability Guidelines indicate that postoperative abduction pillow slings are recommended following the open repair of a large and massive rotator cuff tear. There was a lack of documentation to support the injured worker had a rotator cuff tear and rotator cuff pathology. The physician was noted to withdrawal the request for the abduction pillow. Given the above, the request for associated surgical services abduction pillow is not medically necessary.