MAXIMUS Federal Services

Case Number:	CM14-0094185		
Date Assigned:	08/08/2014	Date of Injury:	12/18/2012
Decision Date:	09/22/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/20/2014

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 Occupational Medicine 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:

This is a 69 year old female with a 12/18/12 injury date. She injured the left shoulder while pulling papers from a computer printout, which the claimant does in large batches throughout the day. In a 6/11/14 progress note, the patient continues to have aching and discomfort in her shoulders. She pain is made worse with reaching and grasping. Objective findings include left shoulder forward flexion to 150 degrees, abduction to 130 degrees, and external rotation to 50 degrees. Impingement signs are present. MRI left shoulder on 3/26/13 noted PASTA lesion of supraspinatus tendon with progression towards adhesive capsulitis. Diagnostic impression: left shoulder impingement syndrome, partial thickness rotator cuff tear. Treatment to date: none documented. A UR decision dated 6/6/14 denied the request for surgery on the basis that an adequate trial of conservative care has not been attempted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic subacromial decompression, distal clavicle resection, bursectomy, rotator cuff repair with debridement as indicated: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability guidelines.

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.

Decision rationale: CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. In the present case, the provided documentation does not show any attempt at prior conservative treatment, which would include cortisone injections and physical therapy. The guidelines for 6 months of conservative care prior to surgery have not been met. Therefore, the request for Left shoulder arthroscopic subacromial decompression, distal clavicle resection, bursectomy, rotator cuff repair with debridement as indicated is not medically necessary.

Surgical Implants: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints,Chronic Pain Treatment Guidelines Page(s): 204, 214.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Gartsman GM. Shoulder Arthroscopy. 2nd Ed. Philadelphia, PA: Elsevier Saunders; 2008.

Decision rationale: CA MTUS does not address this issue. The use of anchor implants is common in rotator cuff repair surgery (Gartsman GM, 2008). Without authorization of the requested surgical interventions for the left shoulder, the medical necessity for surgical implants is not established. Therefore, the request for surgical implants is not medically necessary.

Post-operative aquatic therapy twice weekly for 4 weeks: 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: Decision based on MTUS Chronic Pain Treatment Guidelines Aqua Therapy Page(s): 22.

Decision rationale: CA MTUS states that aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy when reduced weight bearing is indicated, such as with extreme obesity. Without authorization of the requested surgical interventions for the left shoulder, the medical necessity for postop aquatic therapy is not established. Therefore, the request for postoperative aquatic therapy twice weekly for 4 weeks is not medically necessary.

Smart Sling: 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.

Decision rationale: CA MTUS does not address this issue. ODG recommends abduction pillow slings as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. Recommend non-certification. Without authorization of the requested surgical interventions for the left shoulder, the medical necessity for smart sling is not established. Therefore, the request for smart sling is not medically necessary.

Polar Ice Unit: 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): Carpal Tunnel Syndrome Chapter.

Decision rationale: CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Specifically, peer-reviewed literature concludes that after carpal tunnel surgery, the use of continuous flow cryotherapy, compared with traditional ice therapy, provides patients with greater comfort and lessens the need for narcotics. Without authorization of the requested surgical interventions for the left shoulder, the medical necessity for polar ice unit is not established. Therefore, the request for polar ice unit is not medically necessary.