

Case Number:	CM15-0064146		
Date Assigned:	04/10/2015	Date of Injury:	04/23/2014
Decision Date:	06/03/2015	UR Denial Date:	03/09/2015
Priority:	Standard	Application Received:	04/03/2015

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: Utah, California
 Certification(s)/Specialty: Orthopedic 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:

The injured worker is a 38-year-old female, who sustained an industrial injury on 04/23/2014. The diagnoses have included impingement syndrome of the right shoulder. Treatment to date has included right shoulder, right elbow and right hand x-rays; cortisone injections and medications. The injured worker presented on 12/18/2014 for an orthopedic consultation. The injured worker reported persistent right shoulder pain with weakness. Upon examination, there was marked distress noted, with positive Neer and Hawkins impingement sign. An x-ray of the right shoulder revealed spurring on the undersurface of the acromion. Treatment recommendations at that time included a diagnostic and operative arthroscopy of the right shoulder with rotator cuff repair. The official MRI of the right shoulder dated 09/15/2014, revealed supraspinatus, subscapularis and infraspinatus tendinopathy; mildly laterally downsloping acromion process; and mild subacromial/subdeltoid bursitis. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

OPA Right Shoulder with PASTA Repair and Acromioplasty, Anchors, and Screws with Assistant Surgeon: Overturned

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-Surgery For Impingement Syndrome,Indications For Surgery-Acrominoplasia.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. Surgery for impingement syndrome is usually arthroscopic decompression. The physician indicates the injured work is in pain and is significantly disabled. The injury is over one year old and the injured worker has had appropriate conservative treatment. Given the above, the request is medically necessary.

Associated Surgical Service: Medical Clearance: 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, Surgery For Impingement Syndrome.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative testing, general.

Decision rationale: The Official Disability Guidelines state, the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities and physical examination findings. There is no documentation of a significant medical history or any underlying comorbidities to support the necessity for preoperative testing. As such, the request is not medically necessary.

Associated Surgical Service: Shoulder Sling (purchase): 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, Surgery For Impingement Syndrome.

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 state, a postoperative abduction pillow sling is recommended following large and massive rotator cuff tears. It is not recommended for arthroscopic surgeries. There is no evidence of a large or massive rotator cuff tear. Therefore, the injured worker does not meet criteria for the requested equipment. As such, the request is not medically necessary.

Associated Surgical Service: Pain Pump (purchase): 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, Surgery For Impingement Syndrome.

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 pain pump.

Decision rationale: The Official Disability Guidelines do not recommend postoperative pain pumps. Three recent RCTs did not support the use of these pain pumps. There was no mention of a contraindication to standard oral pain medication as opposed to a pain pump. Based on the above-mentioned guidelines, the request is not medically appropriate.

Associated Surgical Service: Interferential Stimulation (1-2 month rental): 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, Surgery For Impingement Syndrome.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-117.

Decision rationale: The California MTUS Guidelines state that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse or significant pain from postoperative conditions. A one-month rental is preferred over a purchase. The request for a 1-2 month rental exceeds Guideline recommendations. As such, the request is not medically appropriate.

Associated Surgical Service: Cold Therapy Unit (purchase): 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, Surgery For Impingement Syndrome.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy for up to seven days following surgery. The injured worker has been issued authorization for the

requested surgical procedure. However, the request as submitted for a cold therapy unit purchase exceeds Guideline recommendations. As such, the request is not medically appropriate.