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| Case Number: | CM15-0099039 | | |
| Date Assigned: | 06/01/2015 | Date of Injury: | 11/01/2011 |
| Decision Date: | 07/07/2015 | UR Denial Date: | 04/29/2015 |
| Priority: | Standard | Application Received: | 05/22/2015 |

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: Illinois, California, Texas
 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 58-year-old female who sustained an industrial injury on 7/9/14. Injury occurred with stacking boxes on a pallet. She underwent right shoulder arthroscopy, acromionectomy, acromioplasty, and partial claviclectomy on 2/16/13. The 4/10/15 treating physician report cited excessive and intense right shoulder pain, causing difficulties in activities of daily living. Sleeping was extremely painful. The right shoulder MRI on 10/21/14 showed no evidence of a full thickness tear, there was supraspinatus tendinitis and fluid in the subacromial subdeltoid bursa and acromioclavicular (AC) joint osteoarthritis. Right shoulder exam documented previous surgical scar, marked tenderness over the right shoulder, tenderness over the acromion, limited range of motion with flexion 120, abduction 90-100, and internal/external rotation 50 degrees. Thumbs down and Neer's sign were positive. The diagnosis included recurrent right shoulder tendonitis and bursitis, impingement syndrome, and osteoarthritis of the AC joint. Authorization was requested for redo right shoulder arthroscopic examination and arthroscopic surgery with subacromial decompression and manipulation under anesthesia, medical clearance, post-op physical therapy 12 sessions, sling, 10-day rental of a cold therapy unit. The 4/29/15 utilization review non-certified the request for right shoulder arthroscopy as there was no evidence of failed recent conservative treatment, including physical therapy and injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Redo arthroscopic examination & arthroscopic surgery with subacromial decompression and manipulation under anesthesia, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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: Surgery for impingement; Surgery for SLAP lesion.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. Manipulation under anesthesia is under study as an option for adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90), manipulation under anesthesia may be considered. Guideline criteria have not been met. This injured worker presents with on-going left shoulder pain causing difficulties with activities of daily living. Clinical exam findings documented limited range of motion and positive impingement test. There is no current documented diagnosis of adhesive capsulitis. There was reported imaging evidence of supraspinatus and AC joint osteoarthritis. However, there was no evidence of a positive diagnostic injection test. Detailed evidence of 3 to 6 months a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Medical clearance: 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.

Postoperative physical therapy , twelve sessions: 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: 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.

Associated Surgical Service: Ten day rental of a cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Continuous flow cryotherapy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.