

Case Number:	CM14-0099105		
Date Assigned:	08/08/2014	Date of Injury:	08/31/2001
Decision Date:	09/15/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	06/27/2014

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 Orthopedic surgery 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 47-year-old female who sustained a vocational injury on 08/31/01. The medical records provided for review document that the claimant had right shoulder arthroscopy in 2003; however, intraoperative findings or the exact date of the surgery are not available. The report of a diagnostic ultrasound on 01/29/14 showed a full-thickness rotator cuff tear on the left shoulder and residual rotator cuff tendinosis of the supraspinatus with evidence of adhesive capsulitis on the right shoulder. The office note dated 06/16/14 noted right shoulder pain and decreased range of motion. Examination of the right shoulder revealed tender to palpation on the subacromial, acromioclavicular, trapezius, pectoral regions, positive impingement and positive pain about the coracoacromial ligament. She had 4+/5 strength testing. Range of motion was 86 degrees of forward flexion, 86 degrees of abduction, 24 degrees of adduction, internal rotation to 60 degrees and external rotation to 62 degrees. The claimant's current working diagnosis is status post right shoulder arthroscopy in 2003 with adhesions, fibrosis, and impingement. This review is for arthroscopic right shoulder evaluation, decompression, distal clavicle resection, capsular release and manipulation under anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Right Shoulder Evaluation, Decompressions. Distal Clavicle, Resection, Capsular Release and Manipulation under Anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Surgery Chapter, Surgery for Impingement Syndrome.

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: Partial claviclectomy (Mumford procedure)ODG Indications for Surgery -- Partial claviclectomy.

Decision rationale: Based on the California MTUS ACOEM Guidelines and the Official Disability Guidelines, the request for arthroscopic right shoulder evaluation, decompression, distal clavicle resection, capsular release and manipulation under anesthesia is not recommended as medically necessary. The ACOEM Guidelines, supported by the Official Disability Guidelines, recommend that there should be continuous conservative treatment for a minimum period of three to six months, which should include antiinflammatories, injection therapy, formal physical therapy, a home exercise program, and activity modification prior to considering and recommending surgical intervention. The ACOEM Guidelines also recommend that there should be documentation of activity limitation for more than four months prior to considering and recommending surgical intervention. Currently, the documentation fails to support that the claimant has had activity limitation and has attempted, failed and exhausted conservative treatment prior to considering surgical intervention. Subsequently, in absence of this documentation and based on the ACOEM Guidelines and Official Disability Guidelines, the request for the arthroscopic right shoulder evaluation, decompression, distal clavicle resection, capsular release and manipulation under anesthesia cannot be considered medically necessary.

Pre-Operative 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 base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: The request for the arthroscopic right shoulder evaluation, decompression, distal clavicle resection, capsular release and manipulation under anesthesia cannot be considered medically necessary. Therefore, the request for preoperative medical clearance is also not medically necessary.

Post-Op Physical Therapy 3 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The request for the arthroscopic right shoulder evaluation, decompression, distal clavicle resection, capsular release and manipulation under anesthesia cannot be considered medically necessary. Therefore, the request for postoperative physical therapy is also not medically necessary.

CPM Device for an initial period of 45 days: 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); Shoulder chapter: Continuous passive motion (CPM).

Decision rationale: The request for the arthroscopic right shoulder evaluation, decompression, distal clavicle resection, capsular release and manipulation under anesthesia cannot be considered medically necessary. Therefore, the request for postoperative use of a CPM is also not medically necessary.

Surgi-Stim Unit for an initial period of 90 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-120.

Decision rationale: The request for the arthroscopic right shoulder evaluation, decompression, distal clavicle resection, capsular release and manipulation under anesthesia cannot be considered medically necessary. Therefore, the request for a Surgi Stim unit is also not medically necessary.

Coolcare 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); Shoulder chapter - Continuous Cold Therapy.

Decision rationale: The request for the arthroscopic right shoulder evaluation, decompression, distal clavicle resection, capsular release and manipulation under anesthesia cannot be considered medically necessary. Therefore, the request for cool care cold therapy unit is also not medically necessary.