

Case Number:	CM14-0144974		
Date Assigned:	09/12/2014	Date of Injury:	03/27/2013
Decision Date:	10/06/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	09/08/2014

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 31-year-old female sustained an industrial injury on 3/27/13 relative to repetitive work activities. Injuries were reported to the low back, upper back and right shoulder. Conservative treatment for the right shoulder included physical therapy, subacromial injection, trigger point injections, activity modification, and medication. The patient last worked on 4/2/14 due to being laid off. The 4/14/14 right shoulder MRI impression documented mild supraspinatus tendinosis with mild lateral down sloping of the distal acromion and normal type 1 morphology. The 6/20/14 treating physician report cited some improvement with right shoulder pain grade 5/10. Pain was reported with repetitive motion, reaching, overhead activities, and laying on the right side. Physical exam documented active right shoulder range of motion as elevation 160, external rotation 90, and internal rotation 30 degrees. Neer, Hawkin's, Speed's and O'Brien's tests were 2+. Shoulder strength was 5/5. There was diffuse tenderness. The patient had a very low tolerance for pain and was very emotional. The treatment plan recommended a corticosteroid injection to the right shoulder. The 8/1/14 treating physician report indicated that the subacromial injection on 7/11/14 provided no benefit. Physical exam was essentially unchanged. The treatment plan recommended right shoulder arthroscopy with subacromial decompression as the patient had failed physical therapy, corticosteroid injection x 2, and home exercise program. MRI findings were positive for bursitis. The 8/13/14 utilization review denied the right shoulder surgery and associated requests based on an absence of imaging evidence of impingement and significant functional deficits. The 8/17/14 treating physician report cited slow recovery and requested additional physical therapy. The patient had good benefit with corticosteroid injection to the right shoulder for 2 days. Symptoms had returned to baseline with diffuse right shoulder pain and improved motion. Physical exam documented diffuse tenderness and normal strength.

Shoulder range of motion had improved to 50 degrees of internal rotation. Impingement tests were 2+. The treatment plan recommended needle therapy and infrared.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy, Subacromial Decompression: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, Shoulder, 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, Surgery for impingement syndrome

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty 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, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have been met. There is no evidence of painful impingement on examination. Imaging findings are associated with an anatomical impingement tendency. There is documentation that comprehensive conservative treatment has been completed and has failed. Therefore, this request is medically necessary.

Sling with Home Exercise Kit: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204-213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213, Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

Decision rationale: As the surgical request is supported, this request is medically necessary for control of pain and protection of the surgical repair.

Post-Op Physical Therapy 2 x 6 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: As the surgical request is supported, this request is medically necessary as it represents 50% of the 24 guideline-supported quantity of post-op physical therapy.

MEDS: Ultracet 37.5/325 TID #10 and Post-Op Norco 10/324 #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Opioids, specific drug list, Tramadol Page(s): 76-80, 91, 93-94, 113.

Decision rationale: As the surgical request is supported, this request is medically necessary to treat the expected relatively severe post-op pain including during periods of "breakthrough" pain.