

Case Number:	CM13-0008544		
Date Assigned:	09/18/2013	Date of Injury:	08/22/2011
Decision Date:	03/17/2014	UR Denial Date:	08/05/2013
Priority:	Standard	Application Received:	08/08/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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:

The patient is a 49 year old male who reported an injury on 08/22/2011. The mechanism of injury was not specifically stated. The patient is currently diagnosed with neck pain, cervical facet pain, cervical degenerative disc disease, low back pain, lumbar degenerative disc disease, shoulder pain, headaches, muscle pain, depression, and chronic pain syndrome. The patient was seen by [REDACTED] on 08/02/2013. The patient reported ongoing left shoulder symptoms. The patient was status post right shoulder arthroscopy, subacromial decompression with acromioplasty, excision of AC joint, capsular repair, and debridement of the rotator cuff and labrum. The patient reported pain at night and painful range of motion of the left shoulder. Physical examination was not provided. Treatment recommendations included approval for a left shoulder arthroscopy with subacromial decompression, acromioplasty, excision of AC joint, capsular repair, rotator cuff repair, and labral repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy Decompressed Excision of AC Joint: 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): 209-210.

Decision rationale: California MTUS/ACOEM Practice Guidelines state 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 that has been shown to benefit from surgical repair. As per the documentation submitted, there was no physical examination on the requesting date of 08/02/2013. There were also no imaging studies provided for review. There is no documentation of an exhaustion of conservative treatment with regard to the left shoulder. The medical necessity for the requested surgical procedure has not been established. Therefore, the request is non-certified.

Labral Repair: 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): 209-210.

Decision rationale: California MTUS/ACOEM Practice Guidelines state 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 that has been shown to benefit from surgical repair. As per the documentation submitted, there was no physical examination on the requesting date of 08/02/2013. There were also no imaging studies provided for review. There is no documentation of an exhaustion of conservative treatment with regard to the left shoulder. The medical necessity for the requested surgical procedure has not been established. Therefore, the request is non-certified.

Physical Therapy (PT), Right Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for fading of treatment frequency plus active self-directed home physical medicine. As per the documentation submitted, the patient is status post right shoulder arthroscopy on 05/13/2013. There was no physical examination provided for review on the requesting date of 08/02/2013. The patient has completed a course of postoperative physical therapy. However, documentation of the previous course of therapy with treatment duration and efficacy was not provided for review. A previous note on 10/07/2013 by [REDACTED] indicated that the patient had full range of

motion of the right shoulder. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.