Case Number:	CM13-0009281		
Date Assigned:	06/06/2014	Date of Injury:	07/27/2012
Decision Date:	07/25/2014	UR Denial Date:	07/18/2013
Priority:	Standard	Application Received:	08/08/2013

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:

The claimant is a 31-year-old who sustained an injury on 07/27/12. The medical records provided for review pertaining to the claimant's left shoulder include the 07/25/13 progress report identifying a diagnosis of shoulder impingement syndrome. The report documented that the claimant had failed conservative care with physical therapy, which was of limited benefit. Objectively, on examination there was restricted motion to 150 degrees of abduction and 90 degrees of active forward flexion. The medical records did not document any other forms of conservative treatment or physical examination findings for the claimant's shoulder. It was noted that a prior MRI scan showed a Type II acromion with mild acromioclavicular joint hypertrophy. There is a current request for shoulder arthroscopy with subacromial decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPY SUBACROMIAL DECOMPRESSION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

Decision rationale: The California MTUS ACOEM Guidelines do not support the proposed left shoulder arthroscopy subacromial decompression. The claimant is diagnosed with impingement. Prior to consideration of surgery, the ACOEM Guidelines recommend conservative treatment including Cortisone injections for three to six months. There is no current documentation of injection therapy for the shoulder. Therefore, the request for surgery, based on the medical records provided for review, cannot be recommended as medically necessary.

POST-OPERATIVE OCCUPATIONAL THERAPY 12 VISITS FOR THE LEFT SHOULDER: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

POST-OPERATIVE DME POLAR UNIT (RENTAL): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

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

CONTINUOUS PASSIVE MOTION(CPM) X 21DAYS (RENTAL): 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) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure -Continuous passive motion (CPM). Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. See the Knee Chapter for more information on continuous passive motion devices. Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment. (Raab, 1996) (BlueCross BlueShield, 2005).

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

ABDUCTION SLING (PURCHASE): 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 Other Guidelines Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Postoperative abduction pillow sling.

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