MAXIMUS Federal Services

Case Number:	CM13-0017892		
Date Assigned:	10/11/2013	Date of Injury:	09/21/2012
Decision Date:	01/02/2014	UR Denial Date:	07/12/2013
Priority:	Standard	Application Received:	08/28/2013

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.

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 54 year old male who sustained an injury to the left shoulder on September 21, 2012. The clinical records include a left shoulder MRI scan reviewed May 16, 2013 that showed moderate grade intrasubstance partial thickness tearing to the supraspinatus with moderate tendinosis to the subscapularis, severe glenohumeral joint arthritis, degenerative labral tearing, moderate glenohumeral joint effusion and moderate acromioclavicular joint degenerative arthritis was noted. The recent clinical progress report from the treating orthopedic physician was June 19, 2013 with Dr. [redacted] for subjective complaints of bilateral shoulder pain with reduced motion and increased pain with overhead activities. Objectively specific to the left shoulder there was positive Neer and Hawkin's testing as well as a positive Jobe's testing. There was crepitation with motion with no documented weakness. Conservative care indicated physical therapy and activity restrictions. Surgical intervention was recommended for the left shoulder in the form of arthroscopic subacromial decompression, Mumford procedure, rotator cuff repair, postoperative physical therapy, cryotherapy unit, a sling and pre-operative medical clearance. The records are from Dr. [redacted] through September 2013 from a psychiatric point of view.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy with subacromial decompression: Upheld

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

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

Decision rationale: Based on the CA ACOEM Guidelines, surgical process to include subacromial decompression would not be supported. The CA ACOEM Guidelines recommend the role of six months of conservative care including injection therapy prior to proceeding with operative intervention for decompression. The records provided for review do not indicate prior injection therapy in this case. The role of surgical process is not supported. The shoulder arthroscopy with subacromial decompression is not medically necessary and appropriate.

Left shoulder arthroscopy for possible rotator cuff repair: Upheld

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

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

Decision rationale: Based on the CA MTUS ACOEM Guidelines rotator cuff repair also is not indicated. The clinical records provided for review indicate partial thickness tearing to the rotator cuff with absence of conservative care including injection therapy. Guidelines recommend a course of conservative care in cases of partial rotator cuff tearing. The request for shoulder arthroscopy with rotator cuff repair is not medically necssary and appropriate.

Left shoulder arthroscopy with possible Mumford procedure: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The CA MTUS ACOEM Guidelines allow for surgery in cases where there is clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. When looking at the ODG criteria, it is stated that there should be objective clinical findings including tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan) and/or pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. In this case, the employee's plain film radiographs and MRI scans demonstrate acromioclavicular joint degenerative changes; however, there is no documentation in the medical records provided for review of physical examination findings showing tenderness over the acromioclavicular joint or pain at the acromioclavicular joint and as such the requested surgical intervention cannot be recommended as medically necessary. The request for the shoulder arthroscopy with possible Mumford procedure is not medically necessary and appropriate.

Pre-operative surgical 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.

Post-operative Physical therapy: 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.

Cryotherapy unit: 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.

Purchase of a 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.