

Case Number:	CM13-0036620		
Date Assigned:	12/13/2013	Date of Injury:	03/10/2007
Decision Date:	02/06/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/21/2013

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 Medicine and is licensed to practice in New Hampshire, New York and Washington. 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 injured his left shoulder March 2007. He and a coworker responded to an emergency call and he injured his shoulder carrying a distressed individual using a cart for transport. He has chronic shoulder pain. He was initially treated with a chiropractor and then referred for an orthopedic surgical consultation. He has visited with a massage therapist for treatment; however, he has not had any attempt at formal physical therapy for her shoulder pain. Shoulder MRI demonstrates bursitis, severe tendinopathy without frank tearing of the rotator cuff. Treatment to date has included acupuncture, chiropractic care and massage therapy. Physical examination documents left shoulder pain and a full range of motion of the left shoulder. No atrophy of his shoulder is present. He has slight left shoulder acromioclavicular joint pain. There is pain to palpation of the subacromial space over the biceps tendon. There is also pain to palpation of the greater tuberosity. There is no scapular winging. Yergason test is positive. The patient has a negative impingement sign, but pain at the extreme of internal rotation. At issue is whether shoulder surgery is necessary at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Surgery Arthroscopy with Bursectomy, SubAcromial Space Decompression, rotator Cuff Debridement Acromioplasty: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, diagnostic arthroscopy section and Surgery Chapter, surgery for impingement syndrome section.

Decision rationale: This patient does not meet established guidelines for left shoulder decompressive surgery. Specifically, the medical records do not clearly document a failure of conservative measures to include physical therapy. There is no documentation of a significant trial and failure of physical therapy. Guidelines recommend subacromial decompression after failure of nonoperative care. In this case the patient has not demonstrated a failure of adequate nonoperative measures to include physical therapy. In addition, there is no documentation of subacromial injection therapy as part of nonoperative care. Guidelines indicate that subacromial injection with cortisone should be carried out with other conservative measures for at least 3-6 months before considering surgery. The medical records do not document an adequate attempt at nonoperative measures to include subacromial injection and a trial of physical therapy for shoulder pain. Established criteria for shoulder surgery not met.

Prospective Assistant Surgeon: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, diagnostic arthroscopy section and Surgery Chapter, surgery for impingement syndrome section.

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

Prospective Post-Op Physical therapy 12 visits: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, diagnostic arthroscopy section and Surgery Chapter, surgery for impingement syndrome section.

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

Prospective Pre-OP EKG: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, diagnostic arthroscopy section and Surgery Chapter, surgery for impingement syndrome section.

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

Prospective Pre-OP Chest X-Ray: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, diagnostic arthroscopy section and Surgery Chapter, surgery for impingement syndrome section.

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

Prospective Pre-Op Basic lab Studies: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, diagnostic arthroscopy section and Surgery Chapter, surgery for impingement syndrome section.

Decision rationale: