

Case Number:	CM13-0039974		
Date Assigned:	12/20/2013	Date of Injury:	01/06/2012
Decision Date:	04/04/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	10/07/2013

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 Pennsylvania. 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 claimant is a 68 year old male who injured the right shoulder in a work related accident on January 6, 2012. The clinical records specific to the claimant's right shoulder identified previous imaging to include a February 9, 2012 MRI report that showed glenohumeral joint effusion with bicipital tendinosis, impingement, and small partial tear to the glenoid labrum. The recent clinical assessment with [REDACTED] documented complaints about the shoulder demonstrating diminished range of motion, tenderness to palpation and positive impingement signs. There was documentation of failed conservative measures including acupuncture, physical therapy and medication management. There was no indication of prior conservative care for injection therapy. At present there is a request for surgical process to include a "right shoulder arthroscopy."

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211, Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation AJSM citations, pg. 297; and The ACC/AHA 2007 Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The Physician Reviewer's decision rationale: Based on the CA ACOEM 2004 Guidelines and supported by the Official Disability Guidelines the surgical request cannot be recommended as medically necessary. Based on review of the medical records provided, the specific needs for operative intervention are unclear demonstrating only a need for "arthroscopy." The claimant's imaging is greater than two years old. There is no documentation of recent conservative treatment to include a corticosteroid injection. The absence of the above information and the date of the claimant's clinical imaging fails to necessitate the role of operative intervention at this stage.

Pre-op medical clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211, Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation AJSM citations, pg. 297; and The ACC/AHA 2007 Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7 Independent Medical Examinations and Consultations, page 127.

Decision rationale: In light of the fact the right shoulder arthroscopy cannot be recommended as medically necessary, the request for preoperative medical clearance also would not be indicated.

Home CPM device X 45 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211, Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation AJSM citations, pg. 297; and The ACC/AHA 2007 Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Continuous passive motion (CPM).

Decision rationale: In light of the fact the right shoulder arthroscopy cannot be recommended as medically necessary, the request for CPM device postoperative would not be recommended as medically necessary.

Post-op PT 3X4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211,Chronic Pain Treatment Guidelines,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation AJSM citations, pg. 297; and The ACC/AHA 2007 Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: In light of the fact the right shoulder arthroscopy cannot be recommended as medically necessary, the request for postoperative physical therapy would not be medically necessary.

Surgi-stim Unit post-op for 90 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211,Chronic Pain Treatment Guidelines,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation AJSM citations, pg. 297; and The ACC/AHA 2007 Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 118, 120.

Decision rationale: In light of the fact the right shoulder arthroscopy cannot be recommended as medically necessary, the request for a surgical stim unit postoperatively would not be medically necessary.

Coolcare Cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211,Chronic Pain Treatment Guidelines,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation AJSM citations, pg. 297; and The ACC/AHA 2007 Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - continuous-flow cryotherapy.

Decision rationale: In light of the fact the right shoulder arthroscopy cannot be recommended as medically necessary, the request for a cryotherapy device in the postoperative setting also would not be indicated.