

Case Number:	CM13-0042549		
Date Assigned:	01/03/2014	Date of Injury:	02/04/2011
Decision Date:	06/26/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	10/30/2013

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, Oklahoma, Tennessee, and Texas. 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 injured worker is a 57-year-old who reported an injury to his left shoulder. No information was submitted regarding the initial injury. The utilization review dated October 22, 2013 resulted in a denial for a left shoulder diagnostic arthroscopy, labral repair, biceps repair, acromioplasty, and distal clavicle excision with a rotator cuff tear repair as no imaging studies had been submitted confirming the injured worker's pathology and no information had been submitted regarding the injured worker's focused physical therapy treatments at the left shoulder. The clinical note dated October 21, 2013 indicates the injured worker complaining of left shoulder pain. The clinical note dated October 14, 2013 indicates the injured worker rating the left shoulder pain as 7/10. The injured worker also reported radiating pain down the left shoulder. Movements at all ranges in the left shoulder exacerbated the patient's pain levels. The clinical note dated October 7, 2013 indicates the injured worker rating the left shoulder pain as 8-9/10. The clinical note dated October 4, 2014 indicates the injured worker having undergone activity modifications, medications, as well as Cortisone injections with some relief. However, the injured worker reported progressively worsening symptoms. Upon exam, the injured worker was able to demonstrate 4+/5 strength with left shoulder elevation and 5-/5 strength with external rotation. The injured worker was identified as having a positive Neer's and Hawkins' sign. There is an indication the injured worker has undergone an MRI at the left shoulder in August of 2011 which revealed findings indicative of a partial rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 LEFT SHOULDER DIAGNOSTIC ARTHROSCOPY, LABRAL, BICEPS, ACROMIOPLASTY, DISTAL CLAVICAL EXCISION AND ROTATOR CUFF TREATMENT: 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): 209-12.

Decision rationale: The documentation indicates the injured worker complaining of left shoulder pain. A surgical procedure is indicated at the left shoulder provided the injured worker meets specific criteria to include imaging studies confirming the injured worker's significant pathology and the injured worker has completed a full three month course of conservative therapy. No imaging studies were submitted for review. Additionally, no information was submitted regarding the injured worker's completion of a three month course of conservative therapies. The request for one left shoulder diagnostic arthroscopy, labral, biceps, acromioplasty, distal clavical excision and rotator cuff treatment is not medically necessary or appropriate.

1 SHOULDER ABDUCTION BRACE (AIRPLANE TYPE): 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) Shoulder Chapter, Post-operative Abduction Pillow.

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

1 PURCHASE OF COLD THERAPY UNIT: 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) Shoulder, Continuous Cryo-Therapy

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

23 HOUR OBSERVATION FOR ANTIBIOTIC PROPHYLAXIS AND PAIN RELIEF: 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) Shoulder Chapter, Hospital Stay

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