

Case Number:	CM13-0046153		
Date Assigned:	12/27/2013	Date of Injury:	12/23/2004
Decision Date:	03/06/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/12/2013

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 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 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 is a 52-year-old female who reported an injury on 12/23/2004, due to cumulative trauma while performing normal job duties. The patient reportedly sustained an injury to the left shoulder. The patient underwent an MRI of the left shoulder in June 2013 that revealed there was evidence of tendinosis and peritendinitis of the supraspinatus tendon with no evidence of tearing, tenosynovitis of the biceps tendon, and arthritic changes of the acromioclavicular joint. The patient's most recent clinical examination finding included restricted range of motion of the left shoulder described as 120 degrees in flexion, 40 degrees in extension, 120 degrees in abduction, 40 degrees in adduction, 80 degrees in external rotation, and 60 degrees in internal rotation. Moderate to severe tenderness to palpation over the acromioclavicular joint was noted with 5/5 strength and a positive impingement test, and acromioclavicular joint compression test. The patient's diagnoses included left shoulder impingement syndrome. The patient's treatment plan included surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic decompression distal clavicle resection, labral and/or cuff debridement.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines. Decision

based on Non-MTUS Citation Official Disability Guidelines,(ODG) Shoulder Chapter; Peer-reviewed literature

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 21-211.

Decision rationale: The requested left shoulder surgery is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does recommend an arthroscopic decompression for impingement syndrome that requires surgical intervention. However, the American College of Occupational and Environmental Medicine recommends patients with mild symptoms or no activity limitations be treated with conservative therapy prior to surgery. The clinical documentation submitted for review does not provide significant activity limitations that would require surgical intervention. Additionally, the clinical documentation does not address a failure to respond to conservative treatments. There is no indication that the patient has participated in an active therapy program, has been treated with medications, or has received any corticosteroid injections. As the patient has not exhausted all lesser forms of interventions, surgery would not be indicated at this time. As such, the requested left shoulder arthroscopic decompression and distal clavicle resection, labral and/or cuff debridement is not medically necessary or appropriate.

CPM 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.

Surgi-Stim 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.

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 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.

Large abduction pillow: 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 for the left shoulder (3 times per week for 4 weeks): 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.