

Case Number:	CM13-0058263		
Date Assigned:	12/30/2013	Date of Injury:	01/04/2013
Decision Date:	06/03/2014	UR Denial Date:	11/04/2013
Priority:	Standard	Application Received:	11/26/2013

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 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 patient is a 38 year old female who sustained a work-related injury on 1/4/13 due to repetitive motions while performing regular duties as a salesperson. The patient complained of left shoulder pain that was treated with six visits of physical therapy, routine medical examinations, and medication. An MRI performed on 10/9/13 revealed mild low grade articular sided fraying and partial cuff tear of junction between supraspinatus/infraspinatus with mild acromioclavicular arthritis. The medical records provided for review indicates that the patient has continued posterior/anterior shoulder pain and pain over the biceps tendon with decreased range of motion. The clinical note dated 10/21/13 indicates left upper extremity posterior supraspinatus abduction 150/160/30/30. Medications include Prednisone 10mg, Cincor 500/20, Synthroid, Aspirin, and Ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION TO INCLUDE MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, subacromial decompression surgery is recommended for the treatment of select patients with impingement syndrome/rotator cuff tendinoses. Subacromial decompression is indicated for all of the following: 1) shoulder joint pain (e.g., symptomatic with positive supraspinatus test, impingement signs); 2) reduced active shoulder range of motion or impaired function 3) imaging findings by MRI or ultrasound of rotator cuff tendinoses consistent with symptoms; and 4) temporary resolution or marked reduction in pain immediately after injection of a local anesthetic into the subacromial space. Patients should also have failed one or more glucocorticosteroid injections. The patient does not meet these criteria. There is no indication that the patient has failed injection therapy and there is no recent documentation to establish the patient's current clinical status. The most recent clinical note provided was dated 10/10/13. As such, the request is not medically necessary.

POSTOPERATIVE PHYSICAL THERAPY THREE TIMES A WEEK FOR THREE 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.

POSTOPERATIVE NORCO 5/325MG #25: 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.