MAXIMUS Federal Services

Case Number:	CM13-0064736		
Date Assigned:	01/03/2014	Date of Injury:	04/15/2011
Decision Date:	05/23/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/12/2013

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 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 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:

This case involves a 49-year-old gentleman, who was injured on 04/15/11, sustaining injuries to the right shoulder, wrist and knee due to cumulative trauma. A prior magnetic resonance angiogram (MRA) of the right wrist from 06/28/13 was unremarkable. A follow-up progress report of 10/23/13, showed subjective complaints of right shoulder pain aggravated with motion and right wrist pain with "popping" and radial and ulnar deviation. Objectively, there was tenderness at endpoints of range of motion of the shoulder, pain over the greater tuberosity to palpation, tenderness over the acromioclavicular (AC) joint and a positive drop arm test and impingement test. The wrist was with restricted motion at endpoints of flexion and extension and instability with radial and ulnar deviation. A 06/19/13 MR arthrogram of the shoulder demonstrated glenohumeral degeneration, a mild acromioclavicular joint separation, and bicep tenosynovitis. It states conservative measures for the shoulder have consisted of physical therapy, anti-inflammatory medications, and work restrictions. Due to the claimant's continued symptoms, surgery was recommended in the form of a right shoulder arthroscopy with "repair of the acromioclavicular joint." There was also a request for a computerized tomography (CT) scan of the right wrist due to increased symptoms and preoperative medical clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

A RIGHT SHOULDER ARTHROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209,211.

Decision rationale: The MTUS/ACOEM Guidelines indicate that surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least three to six (3-6) months before considering surgery. The Guidelines also indicate that patients with acromioclavicular (AC) joint separation may be treated conservatively. The expected period of pain is three (3) weeks, with the pain gradually decreasing. If pain persists after recovery and return to activities, resection of the outer clavicle may be indicated after six (6) months to one (1) year, although local cortisone injections can be tried. The treating physician indicates surgery would be for decompression as well as repair to separated AC joint. The records do not indicate that a previous injection has been provided. Guideline criteria would indicate the need for injections for both the diagnosis of impingement and recalcitrant pain with AC joint separation history prior to proceeding with the procedure. Absence of the above would fail to support the role of the proposed surgery.

A COMPUTERIZED TOMOGRAPHY (CT) SCAN OF THE RIGHT WRIST: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258-262. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) TREATMENT INWORKER'S COMPENSATION, 18TH EDITION, 2013 UPDATES: FOREARM, WRIST, HAND PROCEDURE - COMPUTED TOMOGRAPHY (CT).

Decision rationale: The MTUS/ACOEM Guidelines state, "If there are no red flags present to indicate serious conditions, the clinician can then determine which common musculoskeletal disorder is present. The criteria follow the clinical thought process, from the mechanism of illness or injury to unique symptoms and signs of a particular disorder, and finally, to test results if any tests are needed to guide treatment at this stage." The Official Disability Guidelines indicate that computerized tomography (CT) scan is recommended in distal radius fractures where there is a high likelihood of intra-articular incongruence, such as fractures in young adults, which frequently result from high-energy impact loading, selective or even routine use of CT to supplement the standard radiographic examination is warranted. The employee has a negative magnetic resonance (MR) arthrogram of the wrist with no documentation of change in physical examination findings or clinical complaints that would warrant further testing. Specific requests for a CT scan of the wrist at this chronic stage in the claimant's course of care would not be supported.

INTERNAL MEDICINE CLEARANCE FOR SURGERY: 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.