

Case Number:	CM13-0065335		
Date Assigned:	01/03/2014	Date of Injury:	01/03/2013
Decision Date:	05/19/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/13/2013

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 Hand 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 injured worker is a 41-year-old female who reported an injury on 01/03/2013. The injured worker reportedly extended her right arm to prevent a box from falling off of a conveyor belt. The current diagnoses include partial-thickness tear of the distal supraspinatus tendon, mild tendinosis of the supraspinatus tendon, tendinosis of the proximal biceps tendon, mild subluxation of the proximal biceps tendon, inferior bony spurring of the acromion, and subacromial bursitis. The injured worker was evaluated on 10/25/2013. The injured worker reported 8/10 cervical spine pain, with radiation to the bilateral upper extremities, 8/10 right shoulder pain, 5/10 left shoulder pain, and 5/10 left wrist pain. The injured worker has been previously treated with activity modification, medications, chiropractic manipulation, electrical stimulation, hot and cold packs, and a right shoulder injection. The injured worker has not Final Determination Letter for IMR Case Number CM13-0065335 3 participated in physical therapy. The physical examination of the right shoulder revealed weakness of the abductors and external rotators, restricted range of motion, exquisite tenderness over the distal end of the right clavicle and acromioclavicular (AC) joint, and painful range of motion. The x-rays obtained in the office on that date indicated no bony joint abnormalities. Treatment recommendations at that time included authorization for an arthroscopic surgery to the right shoulder with preoperative medical clearance, durable medical equipment, postoperative medications, and postoperative therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY WITH ARTHROSCOPIC SURGERY WITH PARTIAL RESECTION OF COROCOACROMIAN LIGAMENT EXTENSIVE DEBRIDEMENT SUBCROMIAL BURSA POSSIBLE REPAIR RTC: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: The MTUS/ACOEM Guidelines indicate that a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than four (4) months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. As per the documentation submitted, the injured worker has not participated in a course of physical therapy. There is no evidence of positive impingement testing upon physical examination. There was no imaging studies provided for review. Based on the aforementioned points, the injured worker does not currently meet criteria for the requested service. As such, the request is non-certified.

MEDICAL CLEARANCE CONSULTATION: CHEST X-RAY, EKG, PFT, LABS (CBC, PT, PITT,CHEM 12): 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.

INTERFERENTIAL CURRENT (IFC) DEVICE: 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 PHYSIOTHERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS QTY: 12 SESSIONS: 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 ACUPUNCTURE TWO (2) TIMES A WEEK FOR SIX (6) WEEKS
QTY: 12 SESSIONS:** 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.

DME: MICRO COOL: 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.

HOME EXERCISE KIT: 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.

DVT COMPRESSION PUMP: 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.

EIGHT (8) STOCKINGS: 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.

SHOULDER ABDUCTION BRACE: 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: EIGHT (8) STOCKINGS

POSTOPERATIVE MEDICATION: KEFLEX 500 MG, #28: 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 MEDICATION: NORCO 10-325 MG, #45: 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 MEDICATION: TRAMADOL 50 MG, #90: 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.