

Case Number:	CM13-0069350		
Date Assigned:	05/07/2014	Date of Injury:	01/02/2001
Decision Date:	07/09/2014	UR Denial Date:	11/18/2011
Priority:	Standard	Application Received:	12/20/2013

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 70 year old male who reported an injury to his left shoulder in 2001. The MRI arthrogram dated 6/22/13 revealed status post SLAP repair. Degenerative changes were also identified at the remainder of the labrum. Chondromalacia was identified at the glenoid and humeral head. Rotator cuff tendinosis was identified without evidence of rotator cuff tear. A clinical note dated 7/15/13 indicated that the patient demonstrated 4/5 strength at the left biceps, bilateral lower trapezius muscles, and left external rotators. The procedure note dated 8/13/13 indicated that the patient underwent Orthovisc injection at the left shoulder. The progress note dated 8/2/13 indicated that the patient was complaining of 10/10 pain following the completion of a physical therapy session. A clinical note dated 11/1/13 indicated that the patient demonstrated 160 degrees of left shoulder flexion, 60 degrees of external rotation, and 70 degrees of internal rotation.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARTHROSCOPIC DEBRIDEMENT, CAPSULAR RELEASE, DECOMPRESSION, OPEN BICEPS TENODESIS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: Clinical documentation indicates the patient complaining of ongoing left shoulder pain with an associated range of motion deficits. Surgical procedures are indicated, provided that the patient meets specific criteria, including imaging studies confirming significant pathology and completion of all conservative treatment. The submitted MRI revealed residual findings at the labrum. However, it is unclear if the patient would benefit from a surgical procedure. No information was submitted regarding the completion of all conservative treatments. The clinical notes indicated the patient undergoing injection therapy. However, no information was submitted regarding completion of a three month course of conservative therapy. Therefore, the appropriateness of the proposed surgical procedure has not been established. The request is not medically necessary.

ASSISTANT SURGEON: 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.

PRE-OPERATIVE MEDICAL CLEARANCE: 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 COLD THERAPY X 2 WEEKS RENTAL: 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.