

Case Number:	CM13-0069686		
Date Assigned:	01/03/2014	Date of Injury:	02/09/2010
Decision Date:	04/29/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	12/23/2013

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 48-year-old female who reported injury on 02/09/2010. The mechanism of injury was noted to be the patient was leaving work and her foot slipped on a pedal causing her to twist her body, fall backwards, and strike her left elbow, left hip, left ankle, and foot on the cement floor while trying to protect her head from striking the ground. The physical examination of 07/01/2013 revealed positive impingement sign and positive AC. The patient's diagnosis was noted to be left shoulder impingement syndrome. The request as submitted was for an arthroscopic left shoulder decompression distal clavicle resection labral and/or rotator cuff debridement, preoperative clearance, postoperative physical therapy sessions, surgical stim unit, XXXXXXXXXX cold therapy unit, and continuous passive motion device. There was no DWC Form RFA or PR-2 submitted nor MRI submitted for the date of requested service.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 ARTHROSCOPIC LEFT SHOULDER DECOMPRESSION DISTAL CLAVICLE RESECTION LABRAL AND/OR ROTATOR CUFF DEBRIDEMENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Partial Claviclectomy(Mumford procedure), and Official Disability Guidelines (ODG), Indications for Surgery- Acromioplasty,

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Partial Claviclectomy, SLAP lesion.

Decision rationale: ACOEM Guidelines indicate that a rotator cuff repair is indicated for patients with significant tears that impair activities caused by weakness of arm elevation or rotation, particularly acutely in younger workers. For partial rotator cuff tears and small thickness tears presenting primarily as impingement surgery, the patient should have failed conservative therapy for 3 months and a subacromial decompression, surgery is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care including cortisone injections should be carried out for at least 3 to 6 months before considering surgery. The ACOEM guidelines do not address distal clavicle resection or labral debridement. As such, secondary guidelines were sought. Official Disability Guidelines indicate that for a partial claviclectomy a patient should have at least 6 weeks of care directed at symptomatic relief prior to surgery and pain at the AC joint along with aggravation of pain with shoulder motion or carrying weight or previous grade 1 or grade 2 AC separation as well as tenderness over the AC joint and/or pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial plus conventional films showing posttraumatic changes of the AC joint or severe DJD of the AC joint. Additionally, SLAP lesion repair is for type 2 and type 4 lesions if more than 50% of the tendon is involved. There was no clinical documentation submitted for review requesting the service. There was no PR-2, no DWC Form RFA, or MRI results submitted for review with this request for the date of service and the service requested. Given the above, the request for 1 arthroscopic left shoulder decompression distal clavicle resection labral and/or rotator cuff debridement is not medically necessary.

1 PRE OP 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.

12 POST OP THERAPY 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.

1 SURGICAL 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.

1 COOLCARE 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.

1 HOME CONTINUOUS PASSIVE MOTION 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.