

Case Number:	CM14-0003885		
Date Assigned:	02/03/2014	Date of Injury:	12/03/2012
Decision Date:	06/20/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/10/2014

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, has a subspecialty in Hand Surgery and is licensed to practice in Illinois. 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 31-year-old male who reported an injury after lifting boxes. The injured worker reportedly sustained an injury to the right shoulder. The injured worker underwent an MRI of the right shoulder on 09/24/2013. It was documented that there was no rotator cuff tear; however, there was evidence of a slight acromion impingement. The injured worker's treatment history included physical therapy, medications, acupuncture, and corticosteroid injections. The injured worker was evaluated on 11/06/2013. Objective findings included right shoulder range of motion described as 90 degrees in abduction and 100 degrees in forward flexion with tenderness to palpation of the greater tuberosity of the humerus and right upper trapezium. The injured worker's diagnoses included right shoulder sprain/strain. The injured worker's treatment plan included right shoulder arthroscopy, subacromial decompression, and rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER SCOPE ARTHROSCOPIC SURGERY WITH SUBACROMIAL DECOMPRESSION AND ROTATOR CUFF REPAIR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9-SHOULDER COMPLAINTS, 209

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004), 12, 210-211

Decision rationale: The requested right shoulder scope arthroscopic surgery with subacromial decompression and rotator cuff repair is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends rotator cuff repair when there are clear physical findings supported by an imaging study of a rotator cuff tear that would benefit from surgical repair. The injured worker's most recent clinical documentation does not provide objective findings to support the diagnosis of a rotator cuff repair. Additionally, the submitted MRI indicated that the injured worker's rotator cuff tendon was intact. Although impingement is noted on the MRI, the injured worker's most recent clinical evaluation does not provide significant clinical examination findings to support this diagnosis. As such, the requested right shoulder scope arthroscopic surgery with subacromial decompression and rotator cuff repair is not medically necessary or appropriate.

MEDICAL CLEARANCE EVALUATION FOR SURGICAL 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.

HOT/COLD CONTRAST UNIT FOR PURCHASE: 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.

ABDUCTION SLING FOR PURCHASE: 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.

