MAXIMUS Federal Services

Case Number:	CM14-0004316		
Date Assigned:	02/03/2014	Date of Injury:	10/03/2012
Decision Date:	06/20/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/09/2014

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 and is licensed to practice in California. 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 has submitted a claim for left shoulder pain associated with an industrial injury date of October 3, 2012. Treatment to date has included medications and home exercise program. Medical records from 2013 were reviewed, which showed that the patient complained of severe left shoulder pain and stiffness with limitation of movement. On physical examination, there was tenderness over the subacromial region. Push button and impingement tests were positive. Range of motion was limited. Ultrasound of the left shoulder dated May 15, 2013 revealed 25% partial thickness left rotator cuff supraspinatus tendon tear, acromioclavicular degenerative joint disease, and subacromial impingement syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPY SUBACROMIAL DECOMPRESSION, DISTAL CLAVICLE RESECTION, ROTATOR CUFF DEBRIDEMENT OR REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 210, 211.

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

Decision rationale: According to pages 209-211 of the ACOEM Practice Guidelines referenced by CA MTUS, rotator cuff repair is indicated for significant tears that impair activities by

causing weakness of arm elevation or rotation. For partial full-thickness and small tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy. In addition, conservative care including cortisone injections can be carried out for at least three to six months before considering surgery. In this case, ultrasound findings revealed only a 25% partial thickness rotator cuff tear with physical findings supporting the diagnosis, wherein the clinical presentation was primarily an impingement syndrome. However, there was no documentation of trial and failure of conservative therapy such as stretching and strengthening exercises or cortisone injections. There is no indication for rotator cuff repair at this time; therefore, the request for surgical intervention is not medically necessary.

POST OPERATIVE PHYSICAL THERAPY LEFT SHOULDER: 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.

CPM RENTAL X 45 DAYS: 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.

COLD THERAPY UNIT RENTAL X 90 DAYS: 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 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.

SURGI STIM UNIT RENTAL X 90 DAYS: 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.