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| Case Number: | CM14-0007117 | | |
| Date Assigned: | 06/11/2014 | Date of Injury: | 12/10/2013 |
| Decision Date: | 07/25/2014 | UR Denial Date: | 12/27/2013 |
| Priority: | Standard | Application Received: | 01/15/2014 |

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 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 53-year-old male who reported injury on 12/10/2013. The mechanism of injury was a fall. The injured worker underwent an MRI of the right shoulder on 12/18/2013 with official findings compatible with acromioclavicular joint injury with disruption of the ligaments in the region of the coracoclavicular ligament with abnormal signal and fluid seen in the coracoclavicular interspace. There was no posterior displacement of the distal clavicle. There was mild vertical caudal displacement of the acromion. There were findings compatible with a full thickness, large, partial tear of the subscapularis tendon and questionable deformity of the anterior labrum. The physical examination of 12/16/2013 revealed the injured worker had x-rays revealing a grade II AC separation. The injured worker had decreased range of motion in the right shoulder with forward flexion, extension, abduction, adduction, external rotation, and internal rotation. The injured worker had tenderness to palpation in the supraspinatus and greater tuberosity. The injured worker had AC joint tenderness and AC joint subluxation as well as a deformity in the right AC joint. The injured worker's muscle strength was 4/5 in forward elevation, abduction, external and internal rotation. The injured worker noted pain with movement of the right shoulder. The injured worker had a positive AC compression test, and impingement 1, 2 and 3 test. The diagnosis included MRI confirmed right grade III AC separation and subscapularis tendon tear. It was indicated the injured worker was status post right shoulder injury on 12/10/2013. The treatment plan included an arthroscopic evaluation, arthroscopic rotator cuff repair and conservative management.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery, Rotator Cuff Repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Diagnostic Arthroscopy.

Decision rationale: The ACOEM Guidelines indicate that surgical consultations may be appropriate for injured workers who have red flag conditions, activity limitation for more than 4 months plus the existence of a surgical lesion upon imaging and objective clinical findings. There should be documentation of a failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus the existence of a surgical lesion. However, the request as submitted was non-specific as to the type of surgery being requested. The Official Disability Guidelines diagnostic arthroscopy criteria was applied. The Official Disability Guidelines indicate that diagnostic arthroscopies should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. The clinical documentation submitted for review indicated the injured worker had objective findings on the MRI. There was a lack of documentation of failure of conservative care. Given the above, the request for a right shoulder arthroscopy is not medically necessary.

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

CPM: 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

ELECTRICAL STIMULATION 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