

Case Number:	CM14-0109449		
Date Assigned:	08/01/2014	Date of Injury:	08/06/2011
Decision Date:	08/29/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/14/2014

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 is a 48-year-old male who sustained a vocational injury on August 6, 2010 while performing lifting duties. The office note dated April 28, 2014 states that the patient was given an injection in his shoulder at his previous appointment which gave about one week of symptom relief. Since the injection, he has increasing pain and popping in his shoulder with constant pain. The patient had arthroscopic right shoulder debridement on December 16, 2011. Conservative treatment to date includes ice, anti-inflammatories, and multiple cortisone injections. On examination, range of motion of the right shoulder was abduction to 150 degrees, forward flexion to 170 degrees, internal rotation to 80 degrees, external rotation to 70 degrees with pain. He had acromioclavicular crepitus noted on range of motion. There was a mild positive Neer impingement and positive Hawkins impingement test. Acromioclavicular joint was tender and there was a positive cross chest arm adduction test. Abduction strength was noted to be 4/5 with mild pain. Radiographs showed no glenohumeral degenerative changes, mild acromioclavicular degenerative changes, type II acromion, but otherwise were within normal limits. The working diagnoses are history of right shoulder labral tearing, rotator cuff tendonitis and acromioclavicular (AC) joint symptoms. This request is for right shoulder arthroscopy, distal clavicle excision, possible rotator cuff repair, and possible labral repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, distal clavicle excision, possible rotator cuff repair, possible labral repair: 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-Shoulder-Partial Claviclectomy.Rotator Cuff Repair.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 9, Shoulder Complaints, pages 209-211 and on the Non-MTUS Official Disability Guidelines (ODG); Shoulder Chapter: Partial Claviclectomy (Mumford Procedure); Indications for Surgery-- Partial Claviclectomy.

Decision rationale: Based on the California ACOEM Guidelines and supported by the Official Disability Guidelines, the request for right shoulder arthroscopy, distal clavicle excision, possible rotator cuff repair, and possible labral repair cannot be recommended as medically necessary. There is no recent imaging study in the form of MRI confirming that there is right shoulder pathology which would be amenable to surgical repair. There is a lack of documentation that the claimant has had continuous conservative treatment for a minimum of three to six months consisting of formal physical therapy and a home exercise program prior to considering surgical intervention for the right shoulder. Therefore, based on the documentation presented for review and in accordance with California MTUS, ACOEM and Official Disability Guidelines, the request for the right shoulder arthroscopy, distal clavicle excision, possible rotator cuff repair and possible labral repair cannot be considered medically necessary.

Post-operative physical therapy x 12 visits: 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.

Slingshot immobilizer: 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: 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.