

Case Number:	CM14-0015795		
Date Assigned:	03/03/2014	Date of Injury:	05/14/2008
Decision Date:	07/08/2014	UR Denial Date:	01/09/2014
Priority:	Standard	Application Received:	02/07/2014

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 and Hand 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 73-year-old male who reported an injury on 07/03/1996 after he closed a box cart on a wheel which reportedly caused injury to his right shoulder. The injured worker was treated with physical therapy and multiple medications. The injured worker ultimately underwent arthroscopic right shoulder surgery on 08/26/2008. A request was made for right shoulder arthroscopy with possible arthroscopic versus open revision of a rotator cuff, labral debridement versus repair decompression acromioplasty, resection of the coracoacromial ligament and/or bursa as indicated, and distal clavicle resection. However, no justification was provided for the request. There was no recent clinical documentation to support the need for surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY, POSSIBLE ARTHROSCOPIC VS OPEN REVISION ROTATOR CUFF, LABRAL DEBRIDEMENT VS REPAIR DECOMPRESSION ACROMIOPLASTY, RESECTION OF CORACOACROMIAL LIGAMENT AND/OR BURSA AS INDICATED, DISTAL CLAVICLE RESECTION:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 210-211.

Decision rationale: The requested right shoulder arthroscopy, possible arthroscopic versus open revision rotator cuff, labral debridement versus repair decompression acromioplasty, resection of the coracoacromial ligament and/or bursa as indicated, distal clavicle resection is not medically necessary or appropriate. The clinical documentation submitted for review did not provide any recent evidence of deficits that would require surgical intervention. The American College of Occupational and Environmental Medicine recommends surgical intervention for the shoulder when there are significant functional deficits supported by an imaging study that have failed to respond to conservative treatment. The clinical documentation does support that the patient has a history of surgical intervention to the right shoulder. However, there was no recent documentation to support the submitted request. As such, the requested right shoulder arthroscopy, possible arthroscopic versus open revision rotator cuff, labral debridement versus repair decompression acromioplasty, resection of the coracoacromial ligament and/or bursa as indicated, distal clavicle resection is not medically necessary or appropriate.

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.

POST-OPERATIVE PHYSICAL THERAPY THREE TIMES PER WEEK FOR SIX WEEKS: 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.

ASSISTANT SURGEON: 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.

E-STIM: 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.

SLING WITH LARGE ABDUCTION PILLOW: 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 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.