MAXIMUS Federal Services

Case Number:	CM14-0018231		
Date Assigned:	04/21/2014	Date of Injury:	05/22/2008
Decision Date:	07/02/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/13/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Arizona. 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 Physician 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 56-year-old male who sustained an injury on May 22, 2008 as a result of a motor vehicle accident. He continues to complain of neck pain with throbbing, numbness and tingling into the upper extremities. He also has left shoulder pain and low back pain. The left shoulder has a positive impingement test with tenderness over the rotator cuff muscles. Mobility is restricted and painful. Examination of 11/6/2013, the patient continues to complain of pain in the left shoulder, neck, upper back, and lower back. The pain radiates into his right upper extremity. Examination of the left shoulder reveals decreased mobility in all planes. There is tenderness to palpation over the greater tuberosity of the humerus. Recommendation is for arthroscopy of the shoulder with a subacromial decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPY WITH SUBACROMIAL DECOMPRESSION:
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): 201, 211.

Decision rationale: The ACOEM guidelines indicate that impingement syndrome injury is associated with chronic rotator cuff degeneration. Night pain is a prominent symptom and the passive range of motion is usually unaffected. Arthroscopic subacromial decompression is the surgical treatment of choice if the symptoms are severe. Conservative care, including cortisone injections can be carried out for at least 3-6 months before considering surgery. There is no documentation of the active or passive range of motion of the shoulder. There is no documentation about the employee's shoulder function. There is no documentation on how much pain the employee is having in his shoulder as opposed to the other areas that are painful. There is no documentation whether the employee has had an injection of a corticosteroid or whether the employee is or was on an evidence-based functional restoration program for the shoulder for 3-6 months. In addition, if passive range of motion is restricted, consideration has to be given to an adhesive capsulitis which can be exacerbated by arthroscopic surgery. Therefore, without this necessary documentation, the medical necessity for arthroscopic surgery and subacromial decompression in this employee has not been established.

INTERNAL MEDICINE 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 FOR POST-OPERATIVE USE: 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 ABDUCTION SLING: 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.