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| Case Number: | CM14-0114204 | | |
| Date Assigned: | 09/26/2014 | Date of Injury: | 11/06/2013 |
| Decision Date: | 11/04/2014 | UR Denial Date: | 06/21/2014 |
| Priority: | Standard | Application Received: | 07/22/2014 |

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 61-year-old female who reported an injury on 11/06/2009. The mechanism of injury was not submitted for clinical review. The diagnoses included shoulder impingement with subacromial bursitis. Previous treatments included medication, rest, ice, modified activity, cortisone injection. In the clinical note dated 06/10/2014, it was reported the injured worker complained of pain in the left shoulder. On the physical examination, the provider noted the left shoulder continued to have provocative impingement findings. The provider requested shoulder arthroscopy, shoulder sling, shoulder orthosis 7 day postop use of polar ice unit, postoperative physical therapy, 1 office consultation, complete echocardiogram, chest x-ray, general health panel of labs. However, a rationale was not submitted for clinical review. The request for authorization was submitted and dated 06/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder arthroscopy surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

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

Decision rationale: The request for shoulder arthroscopic surgery is not medically necessary. The California MTUS/ACOEM Guidelines note surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. The request submitted failed to provide which shoulder the surgery is to be performed on. The request submitted additionally failed to provide the specific type of surgery to be performed. Therefore, the request for Shoulder Arthroscopy Surgery is not medically necessary.

Shoulder sling, shoulder immobilizer QTY: 2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 2014, Shoulder, continuous flow cryotherapy, postoperative abduction pillow sling

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.

Shoulder orthosis, figure of 8 design abduction restrainer canvas: 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.

7 day post op use of polar ice unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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-op physical therapy 2 x 4: 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.

1 office consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopedic Surgeons, Orthopedic Knowledge Update

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.

Complete electrocardiogram: 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.

Chest x-ray: 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.

General health panel: Comprehensive metabolic panel, blood count (CBC), automated differential WBC count, or blood count, complete CBC (automated) and appropriate manual differential WBC count, thyroid stimulation hormone (TSH): 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.

