MAXIMUS Federal Services

Case Number:	CM14-0119036		
Date Assigned:	08/06/2014	Date of Injury:	02/06/2008
Decision Date:	09/12/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	07/29/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 46 year old female who was injured on February 06, 2008. The mechanism of injury is described as a pop in the right shoulder while making a hotel bed. The injured worker was diagnosed with rotator cuff impingement, partial cuff tear, acromioclavicular (AC) joint arthritis and possible labral tear. Partial rotator cuff tear was determined by MRI performed in July of 2013. A progress note dated May 15, 2014 noted temporary right shoulder pain relief with cortisone injection. The progress note further documented right shoulder pain was aggravated by abduction, overhead use and lifting. Positive O'Brien test and positive impingement sign noted. Mild pain and weakness with rotator cuff strength testing is also noted. Biceps were symmetrical. Motor and sensory exams were normal. Continued complaints of dull/achy right shoulder pain with pain rated as 7/10 with medication (Hydrocodone). Treatment to date included physical therapy, medication, and plan for surgery. The prior utilization review (UR) determination dated July 18, 2014 resulted in denial of right shoulder surgery because guidelines require three to six months of conservative treatment prior to surgical intervention. The prior UR decision also non-certified pre-op labs, post-op physical therapy (12), cold therapy unit, and immobilizer durable medical equipment purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopic Acromioplasty, Mumford, Possible Labral Repair, Possible Rotator Cuff Repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Updated 4/25/14) ShoulderOfficial Disability Guidelines (ODG) Shoulder (Updated 4/25/14) Indications for Surgery.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Acromioplasty, Indications for surgery.

Decision rationale: Per guidelines, rotator cuff repair is indicated for a significant tear which impairs activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. Surgical repair is reserved in cases of partial thickness tear or small full thickness tear presenting primarily with impingement in which conservative treatments for at least 3 to 6 months have failed, because they have similar results without the risks of surgery. In this case, there is no documentation of significant impaired activities. There is no record of at least 3 to 6 months conservative management such as physical therapy. Therefore, the requested procedure is not medically necessary.

Pre-Op Labs: CBC / CMP / A1C: 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) Low Back (Updated 7/3/14).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Acromioplasty, Indications for surgery.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-Op Physical Therapy x12 Visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post Surgical Treatment Guidelines Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Acromioplasty, Indications for surgery.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Cold Therapy Unit - Purchase: 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), Continuous-Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since Right Shoulder Arthroscopic Acromioplasty, Mumford, Possible Labral Repair, Possible Rotator Cuff Repair is not medically necessary, there is no need for post-op PT; thus is not medically necessary.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Immobilizer Purchase: 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): Shoulder, Immobilization.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Acromioplasty, Indications for surgery.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.