

Case Number:	CM14-0129201		
Date Assigned:	08/18/2014	Date of Injury:	08/04/2011
Decision Date:	09/15/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/13/2014

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 claimant is a 38-year-old gentleman who injured his right shoulder in work related accident on 08/04/11. Records provided for review document that the claimant was status post right shoulder arthroscopy, SLAP repair, and rotator cuff repair procedure on 02/14/12. Following postoperative treatment, the claimant underwent a second surgical arthroscopy for labral repair, revision bicep tenodesis, and rotator cuff debridement. The records following the second surgery include the report of a postoperative MRI of the shoulder dated 10/02/13 identifying no rotator cuff tearing, positive acromioclavicular joint degenerative change, and positive tendinosis of the rotator cuff. The office note dated 07/09/14 documented continued complaints of pain in the shoulder despite a recent acromioclavicular joint injection. Physical exam showed active motion to 120 degrees of forward flexion, 85 degrees of external and internal rotation, and 160 degrees of passive flexion. Strength was noted to be stable with pain on resisted abduction. There was positive and painful Speed's testing and tenderness to the acromioclavicular joint. Based on claimant's failed conservative measures, the recommendation was made for revision arthroscopy, subacromial decompression, Mumford procedure, and manipulation under anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy Manipulation Mumford: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation (ODG) Shoulder Chapter ACOEM Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp , 18th Edition, 2013 Updates: shoulder procedure - Manipulation under anesthesia (MUA); Mumford Procedure.

Decision rationale: criteria would not recommend the request for Right Shoulder Arthroscopy, Manipulation, and Mumford procedures. The medical records provided for review do not identify physical examination findings to require the need for a manipulation under anesthesia as the claimant's current motion is documented to be greater than 120 degrees. There is also no documentation that the claimant received an intrarticular Corticosteroid injection of the AC joint. Presently the ACOEM Guidelines would not support the need for a revision decompression procedure without documentation of imaging supporting an anatomic defect to the shoulder with three to six months of conservative care including subacromial Corticosteroid procedure. Request for surgical intervention in this case has not been established.

12 Sessions of Post-Op Physical Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

TENS Unit 4-Lead: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) / Transcutaneous electrotherapy Page(s): 114-115,116.

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

Polar Care: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205,555-556.

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

Sling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Postoperative abduction pillow sling.

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

