

Case Number:	CM14-0133770		
Date Assigned:	08/25/2014	Date of Injury:	01/23/2007
Decision Date:	10/02/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/19/2014

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 allergy & Immunology 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:

This 60 year old male sustained an injury 1/23/07 while trying to hold up a 300 pound file cabinet that was falling. This put a strain on his entire body. The right shoulder was accepted by the carrier. An MRI of the right shoulder 7/15/14 did not demonstrate a definite SLAP tear. The prior biceps labral anchor was intact. Positive bursitis was identified. There was a mild tenosynovitis of the long head of the biceps in the bicipital groove. There were degenerative changes of the acromioclavicular joint. There were changes involving the superior and inferior acromioclavicular ligaments consistent with sub-acute to chronic sprains suggesting an element of ongoing acuity. Examination 7/23/14 identified a positive impingement sign. The patient has problems with overhead reaching, pain with range of motion. The plan that date was home exercise program and anti-inflammatories and then "surgery in 2-3 months if not improved."

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209; 210-211.

Decision rationale: As of 8/13/14, the requesting provider documented that the patient had completed physical therapy twice a week for a total of 12 sessions. The requesting provider requested reconsideration. An IMR was filed. Considering the additional information, conservative management has failed. Therefore, the request for right shoulder surgery arthroscopy is medically necessary. "Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation."

Right Shoulder SAD, Mumford Procedure: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209; 210-211.

Decision rationale: As of 8/13/14, the requesting provider documented that the patient had completed physical therapy twice a week for a total of 12 sessions. The requesting provider requested reconsideration. An IMR was filed. Considering the additional information, conservative management has failed. Therefore, the request for right shoulder surgery SAD is medically necessary. "Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation."

Assistant Surgeon (PA-C): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare & Medicaid Services (CMS), Assistant Surgeons

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://cms.gov/apps/physician-fee-schedule/overview.aspx>,

Decision rationale: The CPT code has not been designated. Medical necessity for an assistant surgeon has not been established for this arthroscopic procedure. Therefore, the request for an assistant surgeon for the rotator cuff repair and subacromial decompression has not been established and the request is denied.

Post-Operative Physical Therapy, Right Shoulder (12 Sessions): Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Medical Treatment Utilization Schedule (MTUS), 2009, Post Surgical, Shoulder. Rotator cuff syndrome/Impingement syndrome

Decision rationale: Medical evidence-based Guidelines support up to 24 physical therapy sessions post op rotator cuff repair. Therefore, the request for physical therapy x 12 is approved.

Post-Operative DME: Shoulder Sling: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)
Treatment: Integrated Treatment/Disability Duration Guidelines, Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 9th Edition (Web), 2011. Shoulder - UltraSling.

Decision rationale: "A standard sling should be all that is needed if the patient simply requires a decompression, distal clavicle excision, or even a biceps tenodesis." Therefore, the request for a standard sling post op is approved as medically necessary.

Post-Operative DME: Cold Therapy Unit: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)
Treatment: Integrated Treatment/Disability Duration Guidelines, Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 9th Edition (web), 2011, Shoulder-Continuous flow cryotherapy.

Decision rationale: The request for cryotherapy the first seven post op days after shoulder surgery has been proven to be beneficial as per evidence-based medical Guidelines. Therefore, this request is approved.