

Case Number:	CM14-0146150		
Date Assigned:	09/12/2014	Date of Injury:	09/16/2013
Decision Date:	11/06/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/09/2014

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 Tennessee. 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 40-year-old male who reported an injury on 09/16/2013. The mechanism of injury was not submitted for clinical review. The diagnoses included right shoulder sprain and right shoulder impingement syndrome. The previous treatments included medication. Within the clinical note dated 08/20/2014, it was reported the injured worker complained of severe shoulder pain. He rated his pain 8/10 in severity. The injured worker complained of pain with elevation of abduction. Upon the physical examination, provider noted the injured worker had painful arc with abduction at 92 degrees and forward flexion at 120 degrees. The provider noted the injured worker's IR iliac crest with rotator cuff weakness. There was a positive Hawkins and crepitus noted on the physical examination. The provider indicated tenderness at the acromioclavicular joint of the right shoulder. The provider noted the injured worker underwent an MRI of the right shoulder, which revealed tendinitis. However, official MRI was not submitted for clinical review. The provider requested a right shoulder arthroscopy, right shoulder physical therapy postop, and durable medical equipment cold therapy units. However, a rationale was not submitted for clinical review. The Request for Authorization was submitted and dated on 08/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

SURGERY RIGHT SHOULDER ARTHROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints Page(s): 211.

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

Decision rationale: The request for surgery for the right shoulder arthroscopy is not medically necessary. The California MTUS/ACOEM Guidelines note the procedure is not indicated for patients with mild symptoms or those who have no limitations of activities, conservative care, including cortisone injections, should be carried out for at least 3 to 6 months prior to considering surgery. The guidelines recommend imaging with the evidence of impingement. There is lack of documentation of imaging studies to support the diagnosis of an impingement warranting the medical necessity for surgery. The clinical documentation submitted failed to indicate the injured worker had tried and failed on conservative therapy including injections for at least 3 to 6 months. The request as submitted failed to provide the specific type of surgery the injured worker was to undergo. Therefore, the request for Surgery Right Shoulder Arthroscopy is not medically necessary.

RIGHT SHOULDER PHYSICAL THERAPY-POST-OP POST-OP PHYSICAL THERAPY X 12 FOR THE RIGHT SHOULDER: Upheld

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

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.

DURABLE MEDICAL EQUIPMENT COLD THERAPY UNIT X 7-DAY RENTAL:
Upheld

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

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.