

Case Number:	CM14-0160822		
Date Assigned:	10/24/2014	Date of Injury:	06/13/2009
Decision Date:	11/25/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	09/30/2014

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:

This 46-year-old male caregiver sustained an industrial injury on 6/13/09. Right shoulder injury occurred when he caught a client who fell. Past surgical history was positive for right shoulder repair on 11/20/12. The 5/22/14 right shoulder MRI impression documented progressive attenuation of the supraspinatus repair with intact posterior fibers remaining and attenuated superior subscapularis insertion, consistent with previous debridement/injury. There was glenohumeral joint osteoarthritis with interval postsurgical changes along the anterior glenoid margin. There was chondral denudation with marginal osteophyte formation and joint effusion. There were postsurgical changes of the acromioclavicular joint with evidence of previous subacromial decompression. Contour irregularity of the humeral head posteriorly and laterally may relate to impingement and/or previous anterior instability. Alignment was anatomic. Records indicate that physical therapy was requested on 5/28/14 with no evidence that this was completed. The 7/9/14 treating physician progress report indicated that the patient was doing poorly with three recent dislocations of his shoulder, reduced in the emergency department. X-rays of the right shoulder showed loss of glenoid bone and successful reduction of the shoulder. The diagnosis was recurrent right shoulder dislocations. The patient had received appropriate non-operative treatment, including physical therapy, medications, injections, bracing, and rest, but remained disabled. The treatment plan recommended shoulder stabilization surgery. The 9/10/14 treating physician report cited grade 5/10 right shoulder pain, popping, swelling and weakness. The shoulder dislocated one week prior and required an emergency room visit. Physical exam documented decreased internal and external rotation strength with recurrent dislocations. The treatment plan recommended proceeding with shoulder stabilization surgery. A right shoulder corticosteroid injection was provided. The 9/24/14 utilization review denied the request for right shoulder surgery as there was no objective documentation to warrant

authorization for surgery, such as positive apprehension findings or documented dislocation 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 lateral Reconstruction: 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: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for shoulder dislocation

Decision rationale: The California MTUS guidelines state that multiple traumatic shoulder dislocations indicate the need for surgery if the shoulder has limited functional ability and if muscle strengthening fails. Surgery can be considered for all patients who are symptomatic with all overhead activities, have had two or three episodes of dislocation and instability that limited their activities between episodes. The Official Disability Guidelines provide specific criteria for shoulder dislocation surgery that includes history of multiple dislocations that inhibit activities of daily living and at least one of the following objective clinical findings: positive apprehensive findings, injury to the humeral head, or documented dislocation under anesthesia. Guideline criteria have not been met. There is no functional assessment documented. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including physical therapy strengthening, and failure has not been submitted. Therefore, this request is not medically necessary.

Surgeon Assistant: 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 med necessary, none of the associated services are medically necessary.

Postoperative Physical Therapy QTY:12: 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 med necessary, none of the associated services are medically necessary.

History and physical, CBC, CMP, PT/PTT, UA, EKG. CXR: 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 med necessary, none of the associated services are medically necessary.

Cold Therapy Unit: 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 med necessary, none of the associated services are medically necessary.

Shoulder Sling: 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 med necessary, none of the associated services are medically necessary.

Pain Pump: 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 med necessary, none of the associated services are medically necessary.