

Case Number:	CM14-0049551		
Date Assigned:	07/07/2014	Date of Injury:	08/28/2003
Decision Date:	08/13/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/17/2014

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, has a subspecialty in Shoulder and Elbow 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 injured worker is a 55-year-old male who reported an injury on 08/28/2003. The mechanism of injury was unknown. The injured worker reportedly sustained an injury to his right shoulder. The injured worker's chronic shoulder pain was managed with medications. The injured worker underwent an MRI on 03/03/2014. Findings included a tear involving the inferior labrum and a labral cyst on the inferior to the glenoid bone and no evidence of a full thickness tear or tenderness retraction. The injured worker was evaluated on 03/06/2014. Physical findings included restricted range of motion of the right shoulder with tenderness over the acromioclavicular joint and a positive impingement sign. The injured worker's diagnosis included rotator cuff shoulder syndrome and allied disorders. A request was made for right shoulder arthroscopic distal clavicle resection, subacromial decompression and labral repair versus labral debridement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic distal clavicular resection, subacromial decompression with labra repair versus labral debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, 214. Decision based on Non-MTUS Citation Official Disability Guidelines- Indications for Surgery--AcromioplastyShoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-212.

Decision rationale: The American College of Occupational and Environmental Medicine recommends surgical intervention for patients who have significant clinical exam findings of functional deficits corroborated by pathology identified on an imaging study that has failed to respond to conservative treatments. The clinical documentation submitted for review does indicate that the injured worker has previously undergone surgical intervention and has positive examination findings of limited range of motion, acromioclavicular joint tenderness, and a positive impingement sign. However, the clinical documentation fails to provide any evidence that the injured worker is currently participating in any type of active physical therapy or other types of conservative treatments in an effort to avoid surgical intervention. Therefore, surgery for the right shoulder would not be supported at this time. As such, the requested right shoulder arthroscopic distal clavicular resection, subacromial decompression with labral repair versus labral debridement is not medically necessary or appropriate.

One sling for right shoulder: 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 medically necessary, none of the associated services are medically necessary..

Cold therapy unit for 1 week rental: 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 medically necessary, none of the associated services are medically necessary.

Twelve (12) post-operative physical therapy visits: 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 medically necessary, none of the associated services are medically necessary.