

Case Number:	CM14-0087945		
Date Assigned:	07/23/2014	Date of Injury:	11/09/2010
Decision Date:	09/10/2014	UR Denial Date:	06/07/2014
Priority:	Standard	Application Received:	06/11/2014

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 is a 74 year old female claimant with a reported industrial injury of 11/9/10. Exam note from 5/12/14 demonstrates report of persistent pain, tenderness, stiffness and weakness of the left shoulder and pain rated as 9/10. Objective findings include decreased range of motion of the left shoulder with left supraspinatus with 4/5 strength in flexion, abduction, and external rotation. Exam demonstrates positive AC joint compression, impingement signs. Prior treatment is noted to include 12 visits of physical therapy, 6 acupuncture treatments, medications and time.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARTHROSCOPIC EVALUATION ARTHROSCOPIC SUBACROMIAL DECOMPRESSION, DISTAL CLAVICLE RESECTION, POSSIBLE ROTATOR CUFF DEBRIDEMENT AND OR REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, 214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Shoulder section, surgery for rotator cuff repair, acromioplasty.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 5/12/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 5/12/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the guidelines criteria have not been met therefore this request is not medically necessary.

PRE OP MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation SURGERY GENERAL INFORMATION AND GROUND RULES, CALIFORNIA OFFICIAL MEDICAL FEE SCHEDULE, 1999 EDITION, PAGES 92-93.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

12 SUPEVISED POST OP PHYSICAL THERAPY SESSIONS: Upheld

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

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

1 HOME CONTINUOUS PASSIVE MOTION DEVICE FOR 45 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, SHOULDER (ACUTE & CHRONIC).

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

1 SURGI STIM UNIT FOR INITIAL PERIOD OF 90 DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

1 COOLCARE COLD THERAPY UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, SHOULDER (ACUTE& CHRONIC).

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.