

Case Number:	CM14-0093405		
Date Assigned:	08/01/2014	Date of Injury:	06/16/2006
Decision Date:	10/03/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/20/2014

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:

The claimant is a 54-year-old female who injured her right shoulder on June 16, 2006. The clinical records provided for review included the report of an MRI of the shoulder dated February 17, 2014 showing supraspinatus inflammation consistent with tendinosis or prior postsurgical repair. There was no indication of full thickness pathology, discrete tearing or any other findings noted. According to the medical records, the claimant had a past surgical history of right shoulder rotator cuff repair more than ten years ago. The progress report dated May 05, 2014 noted examination findings of a positive Hawkins and Neer testing for the diagnosis of shoulder impingement that has failed conservative treatment. The records document a prior injection in 2013, but do not identify any recent physical therapy or other forms of treatment rendered. The recommendation was made for arthroscopy, subacromial decompression, labrum and rotator cuff repair as needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder diagnostic arthroscopy, Subacromial Decompression and tissue repair labrum or rotator cuff surgery.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: Shoulder procedure - Surgery for SLAP lesions.

Decision rationale: Based on the California MTUS ACOEM Practice Guidelines, the request for right shoulder diagnostic arthroscopy, subacromial decompression and tissue repair of the labrum or rotator cuff cannot be recommended as medically necessary. The medical records provided for review do not identify any labral or rotator cuff pathology on imaging that would support the acute need for an operative process. The ACOEM Practice Guidelines recommend that conservative care, including cortisone injections, be carried out for at least three to six months before considering surgery. The medical records do not confirm that the claimant has had six months of recent conservative care including injection therapy; there is only documentation of a prior isolated injection in 2013. Given the claimant's current imaging findings and lack of recent conservative care, the operative process in question would not be supported.

Medical clearance, Labs, EKG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for right shoulder diagnostic arthroscopy, subacromial decompression and tissue repair of the labrum or rotator cuff cannot be recommended as medically necessary. Therefore, the request for medical clearance for preoperative testing is also not recommended as medically necessary.

Right shoulder X-Ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for right shoulder diagnostic arthroscopy, subacromial decompression and tissue repair of the labrum or rotator cuff cannot be recommended as medically necessary. Therefore, the request for shoulder plain film radiographs is also not medically necessary.

Chest X-Ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7 Independent Medical Examinations and Consultations, page 127. Introduction The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in

Decision rationale: The request for right shoulder diagnostic arthroscopy, subacromial decompression and tissue repair of the labrum or rotator cuff cannot be recommended as medically necessary. Therefore, the request for a chest x-ray is also not medically necessary.

Shoulder sling with abduction pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for right shoulder diagnostic arthroscopy, subacromial decompression and tissue repair of the labrum or rotator cuff cannot be recommended as medically necessary. Therefore, the request for postoperative use of an abduction pillow is also not medically necessary.

Cold Unit (30-day rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for right shoulder diagnostic arthroscopy, subacromial decompression and tissue repair of the labrum or rotator cuff cannot be recommended as medically necessary. Therefore, the request for a cold unit is also not medically necessary.

Pain pump: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for right shoulder diagnostic arthroscopy, subacromial decompression and tissue repair of the labrum or rotator cuff cannot be recommended as medically necessary. Therefore, the request for a pain pump is also not medically necessary.

Post Surgical Physical Therapy (2-times per week for 4-weeks): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for right shoulder diagnostic arthroscopy, subacromial decompression and tissue repair of the labrum or rotator cuff cannot be recommended as medically necessary. Therefore, the request for eight sessions of postoperative physical therapy is also not medically necessary.