

Case Number:	CM14-0193742		
Date Assigned:	12/01/2014	Date of Injury:	07/26/2010
Decision Date:	01/16/2015	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	11/17/2014

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 Surgeon, has a subspecialty in Surgery of the Hand and is licensed to practice in Hawaii, Washington and Maryland. 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 38-year-old female who reported an injury of unspecified mechanism on 07/26/2010. A report of an MRI of the right shoulder on 09/20/2014, contained in a physician's note of 09/22/2014, reportedly revealed "no evidence of rotator cuff tear or labral tear". The clinical impression was "significant right shoulder impingement/subacromial bursitis, status post industrial right shoulder sprain/strain incident on 07/26/2010". Her symptoms of right shoulder pain and functional limitation persisted despite 3 cortisone injections, more than 30 visits of physical therapy, home exercises, and home cryotherapy. Her right shoulder ranges of motion measured in degrees were forward flexion 125/180, extension 40/50, abduction 125/180, adduction 40/50, external rotation 80/90, and internal rotation 45/90. There was tenderness noted to the supraspinatus muscles on the right side along with the greater tuberosity and the biceps tendon. She had moderate AC joint tenderness and subacromial crepitus. She had a positive AC joint compression test, impingement test with forward elevation internal rotation and abduction. She has had symptoms for over 4 years despite intense and aggressive conservative management and remains an excellent candidate for at least a right shoulder diagnostic arthroscopy, arthroscopic subacromial bursectomy, chondroplasty, and debridement. A request for authorization dated 09/22/2014 was included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder diagnostic arthroscopy, arthroscopic subacromial bursectomy, chondroplasty and debridement: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Diagnostic arthroscopy.

Decision rationale: The decision for right shoulder diagnostic arthroscopy, arthroscopic subacromial bursectomy, chondroplasty and debridement is not medically necessary. The Official Disability Guidelines recommend diagnostic arthroscopy in cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. This injured worker's unofficial MRI showed no rotator cuff or glenoid labral tear. She has failed all efforts at conservative treatment over a 4 year period. She has ongoing pain and functional limitations. The official MRI report would be needed prior to considering this procedure. Therefore, this request for right shoulder diagnostic arthroscopy, arthroscopic subacromial bursectomy, chondroplasty and debridement is not medically necessary.

Associated surgical services: Standard Pre-operative medical clearance: 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.

Associated surgical services: Home continuous passive motion (CPM) device initial period of 45 days: 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.

Associated surgical services: Surgi stim unit initial period of 90 days; then purchase: 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.

Associated surgical services: Coolcare 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 medically necessary, none of the associated services are medically necessary.