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| Case Number: | CM14-0203555 | | |
| Date Assigned: | 12/16/2014 | Date of Injury: | 02/12/2014 |
| Decision Date: | 02/20/2015 | UR Denial Date: | 11/21/2014 |
| Priority: | Standard | Application Received: | 12/05/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

39 year old female claimant with an industrial injury dated 02/12/14. Exam note 11/10/14 states the patient returns with shoulder pain. The patient explains experiencing pain over the lateral aspect of the shoulder that increases with reaching or overhead activities. The patient explains that she had a painful arc of motion and the pain increases at night. Upon physical exam the patient revealed a forward flexion of 160', external rotation of 70', extension of 40', and an internal rotation of 40' with the right shoulder. Sensation is noted as normal, and the patient had normal stability as well. There was evidence of 3+ tenderness over the acromioclavicular joint and impingement signs were noted as 2-3+ positive. The patient had a motor strength of 4/5 and the neurovascular exam was intact. Diagnosis is noted as right shoulder impingement syndrome with acromioclavicular joint arthritis. MRI right shoulder 4/29/14 demonstrates posterior superior labral tear with otherwise normal study. Treatment includes a right shoulder arthroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, subacromial decompression, distal clavicle resection, arthroplasty and rotator cuff repair: Upheld

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

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, Surgery for rotator cuff repair

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 do not demonstrate 4 months of failure of activity modification. The physical exam from 11/10/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. The MRI of the right shoulder demonstrates a labral tear but no evidence of rotator cuff tear. Therefore the determination is for not medically necessary.

Ultrasling with pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

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.

14 day rental of a cold therapy: 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: 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.

Assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare & Medicaid Services

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.

12 post operative physical therapy visits: Upheld

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

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.