

Case Number:	CM15-0001620		
Date Assigned:	01/13/2015	Date of Injury:	04/11/2014
Decision Date:	04/02/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/05/2015

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: Minnesota, Florida

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:

The injured worker is a 41 year old male who sustained an industrial injury on 4/11/2014. He has reported turning a tractor over in a ditch and injured his head, neck, back, bilateral knees and left shoulder. The diagnoses have included neck pain, left shoulder pain, low back pain, lower spine musculoligamentous strain/sprain, lumbago and cervicgia. Treatment to date has included medication, back brace, rest and physical therapy. Left shoulder electromyography (EMG) was negative for nerve damage. Left shoulder arthrogram showed no rotator cuff tear. Currently, the IW complains of left shoulder pain and left arm numbness. Treatment plan from 10/22/2014 included left shoulder arthroscopy, surgical assistant, 18 physical therapy visits post-operative, 21 days of continuous passive motion unit and 21 days of use of a cryotherapy unit. On 12/24/2014, Utilization Review non-certified left shoulder arthroscopy, noting the lack of conservative treatment as the injured worker declined physical therapy and noncertified the surgical assistant, 18 physical therapy visits post-operative, 21 days of continuous passive motion unit and 21 days of use of a cryotherapy unit, noting the non-certified surgery and lack of medical necessity. The MTUS, ACOEM Guidelines, (or ODG) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery- 1 left shoulder arthroscopy, debridement, subacromial decompression, and rotator cuff tendon repair.: Upheld

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

Decision rationale: California MTUS guidelines recommend surgical considerations for activity limitation for more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. Surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care including cortisone injections and physical therapy may be carried out for at least 3-6 months before considering surgery. The documentation indicates that the injured worker refused physical therapy and injections. Documentation indicates good motion in the shoulder and weakness due to lack of maximum effort. The MR arthrogram showed a pinhole in the supraspinatus tendon but no significant rotator cuff tear was identified. There was no acromioclavicular arthritis noted. Based upon the absence of a recent comprehensive nonoperative treatment program with injections and exercises for 3-6 months, the guideline requirements are not met and as such the request for arthroscopy with subacromial decompression is not supported and the medical necessity of the request is not substantiated. The imaging studies do not support the request for a rotator cuff repair and as such, in the absence of evidence of a significant full thickness rotator cuff tear the guideline criteria for a rotator cuff repair are not met and the medical necessity is not established.

Associated surgical services: Surgical Assistant: 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: 21 Days Use of Continuous Passive Motion (CPM) 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.

Associated Surgical Service: Post Operative Physical Therapy, 18 sessions: 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: 21 Days Use of Cryotherapy 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.