

Case Number:	CM15-0006100		
Date Assigned:	01/20/2015	Date of Injury:	05/20/2014
Decision Date:	03/20/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	01/12/2015

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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 46-year-old male who reported an injury on 05/20/2014. The mechanism of injury was not provided. On 11/25/2014, the injured worker presented with a chief complaint of left shoulder pain. Upon examination of the left shoulder, there was full passive motion with pain at end ranges of flexion and abduction. Active range of motion is limited to 160 degrees of flexion, 140 degrees of abduction, internal and external rotation at 70 degrees. There is 4/5 strength with flexion, abduction, and external rotation. Diagnoses were status post rotator cuff repair of the left shoulder 04/16/2013 and tendinitis of the left shoulder. There was continued painful range of motion with weakness. The provider recommended a left shoulder diagnostic arthroscopy, a surgical assistant, postoperative pain medication of Percocet 5/325 mg #60, physical therapy 3 times a week for 12 weeks, postoperative arc brace, and postoperative cold compression unit for 7 days. The provider stated that the injured worker had undergone therapy without improvement, and therefore is recommending surgery. The Request for Authorization form was not included in the medical document for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder diagnostic arthroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Diagnostic Arthroscopy Section

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Diagnostic Arthroscopy.

Decision rationale: The request for left shoulder diagnostic arthroscopy is not medically necessary. California MTUS/ACOEM Guidelines state that surgical consultation would be indicated for injured workers who have red flag conditions, activity limitations for more than 4 months with 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. The Official Disability Guidelines further state that a diagnostic arthroscopy is recommended in cases where imaging is inconclusive and acute pain or functional limitations continue despite conservative care. The documentation submitted for review lacked evidence of imaging studies, evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. The provider noted that the patient had undergone conservative treatment without improvement. However, there is no mention of what types of conservative therapy the injured worker underwent. There should be evidence of prior injections, physical therapy, and medication management. As such, medical necessity has not been established.

Related surgical service: 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.

Post-operative Percocet 5/325 mg, sixty count: 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.

Post-operative physical therapy, three times weekly for twelve weeks: 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.

Post-operative Arc Brace only for repair: 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.

Post-operative cold compression nit for seven 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.