

Case Number:	CM15-0008192		
Date Assigned:	01/23/2015	Date of Injury:	03/22/2013
Decision Date:	03/20/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/14/2015

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 55-year-old female who reported an injury on 03/22/2013. The mechanism of injury was reportedly when she was swinging a bottle and felt a twisting injury to her shoulder. Her diagnoses include impingement syndrome of the left shoulder. Other therapies were noted to include physical therapy and medications. An MRI of the left shoulder revealed no evidence of acute marrow contusion, rotator cuff tear or evidence of labral pathology, and mild to moderate acromioclavicular joint degenerative changes with small subacromial osteophytosis mildly increased for risk of impingement. On 02/19/2014, it was indicated the injured worker had complaints of a shoulder pain and weakness that was exacerbated by overhead activities. Upon physical examination, it was indicated the injured worker had tenderness about the anterior aspect of the shoulder with no spasm. Her range of motion was limited, measuring flexion and abduction at 160 degrees, internal rotation at 10 degrees and external rotation at 20 degrees. Her grip strength measured 10 on the left and 30 on the right. Her motor strength measured 4+/5 for the supraspinatus. Sensation was intact, and she had a positive impingement test. Relevant medications were not included in the report. The treatment plan was noted to include physical therapy and medications. A request was received for left shoulder acromioplasty and PASTA repair and Mumford procedure, suture anchors and screws; associated surgical services: assistant surgeon; associated surgical services: medical clearance, labs-CBC, CMP, PT-PTT, UA, EKG, CXR; post-op physical therapy 3 x 4 weeks; associated surgical services: left shoulder/post cold therapy unit, purchase; associated surgical

services: shoulder sling, purchase; associated surgical services: pain pump, purchase; associated surgical services: IF unit - 1 month rental without a rationale.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder acromioplasty and PASTA repair and mumford procedure; Suture anchors and screws: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: According to the California MTUS/ACOEM Guidelines, surgery is indicated for those who have red flag conditions, activity limitation for more than 4 months, failure to increase function despite exercise programs, and clear clinical and imaging evidence of a lesion. The guidelines also indicated that surgery for impingement syndrome is not indicated for those with mild symptoms or no activity limitations. The guidelines also indicate that rotator cuff repair is indicated for significant tears impairing activities. The MRI submitted for review did not indicate evidence of a rotator cuff tear, though it was noted the injured worker had mild to moderate acromioclavicular joint degenerative changes with mild acromial osteophytosis. There is no documentation indicating red flag conditions, the failure to increase range of motion and strength, and there is no recent clinical documentation since the MRI noting functional status. Consequently, the request is not supported by the evidence based guidelines. As such, the request for left shoulder acromioplasty and PASTA repair and Mumford procedure; suture anchors and screws is not medically necessary.

Associated surgical services: assistant surgeon: 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: medical clearance; labs-CBC, CMP, PT-PTT, UA, EKG, CXR: 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-op physical therapy 3 x 4 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.

Associated surgical services: left shoulder/post cold therapy unit, 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: shoulder sling, 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: pain pump, 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: IF unit - 1 month rental: 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.