

Case Number:	CM15-0108802		
Date Assigned:	06/15/2015	Date of Injury:	01/06/2014
Decision Date:	09/08/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/05/2015

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: 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:

The 45-year-old female injured worker suffered an industrial injury on 01/06/2014. The diagnoses included partial thickness tendon tear 75 percent. The diagnostics included ultrasound of the bilateral shoulder. The injured worker had been treated with acupuncture and medications. On 4/13/2015 exam reported there was restricted range of motion to the right greater than left shoulders. The right shoulder had severe tenderness and painful range of motion with positive impingement signs. The treatment plan included Arthroscopic right shoulder evaluation, arthroscopic subacromial decompression, distal clavicle resection and rotator cuff debridement vs. repair, Supervised post-operative physical therapy, CPM device, shoulder immobilizer- abduction pillow, Surgistim unit, and continuous cryotherapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic right shoulder evaluation, arthroscopic subacromial decompression, distal clavicle resection and rotator cuff debridement vs. repair: 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): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty surgery.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 4/13/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case, the exam note from 4/13/15 does not demonstrate evidence satisfying the above criteria including specific details of 3-6 months of conservative care. Therefore, the request is not medically necessary.

Supervised post operative physical therapy sessions following right shoulder surgery, 12 visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical services: Home use of a CPM device following right shoulder surgery 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, CPM.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical services: Shoulder immobilizer-abduction pillow following right shoulder surgery: 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, Abduction pillow.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical services: Surgistim unit 90 days following right shoulder surgery:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 118-119.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-operative use of a continuous cryotherapy unit following right shoulder surgery:
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, Continuous flow cryotherapy.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.