

Case Number:	CM15-0010660		
Date Assigned:	01/28/2015	Date of Injury:	02/03/2014
Decision Date:	04/03/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/20/2015

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: New York
Certification(s)/Specialty: Neurological 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:

This 52 year old male firefighter sustained an industrial injury on 2/3/14. The injured worker reported symptoms in the bilateral shoulders, But predominantly on the right. He underwent a right shoulder arthroscopic subacromial decompression and acromioplasty-Mumford procedure on 08/15/2014. Treatments to date have included "failed outpatient conservative therapy". Provider documentation dated 7/29/14 noted the injured worker presents with "chronic, severe right shoulder pain for several years. Post operatively the patient began a physical therapy program directed at the right shoulder. Documentation does not provide evidence of an exercise, physical therapy or medication program directed to the left shoulder. The treating physician requested a left shoulder diagnostic/operative arthroscopic debridement with acromioplasty, resection of coracoacromial ligament and bursa as indicated and possible distal clavicle resection, post-operative physical therapy, 12 sessions to the left shoulder, post-op sling purchase, and medical clearance complete blood count, complete metabolic panel, prothrombin/Partial Thromboplastin Time, hepatitis panel, human immunodeficiency virus panel, urinalysis, electrocardiogram and chest X-ray. On 12/24/14, Utilization Review non-certified a request for a left shoulder diagnostic/operative arthroscopic debridement with acromioplasty, resection of coracoacromial ligament and bursa as indicated and possible distal clavicle resection, post-operative physical therapy, 12 sessions to the left shoulder, post-op sling purchase, and medical clearance complete blood count, complete metabolic panel, prothrombin/ Partial Thromboplastin Time, hepatitis panel, human immunodeficiency virus panel, urinalysis, electrocardiogram and chest X-ray. 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:

Post-operative physical therapy, 12 sessions to the left shoulder: 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.

Left Shoulder Diagnostic/Operative Arthroscopic Debridement With Acromioplasty:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 219. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery--Acromioplasty.

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

Decision rationale: The California MTUS guidelines note that arthroscopic decompression is not recommended for those patients who have mild symptoms and no activity limitations. Documentation does not describe the patient's left shoulder complaints or improvement in the range of motion. Surgical consultation is recommended for those patients not responding to an exercise and physical therapy program to increase strength and range of motion. The MTUS guidelines recommend conservative care including cortisone injections can be carried out at least three to six months before considering surgery. This patient's documentation does not describe an exercise or physical therapy program directed to the left shoulder. Thus the requested treatment: Left shoulder diagnostic/operative arthroscopic debridement with acromioplasty is not medically indicated and appropriate.

Resection of Coracoacromial Ligament and Bursa as Indicated and possible Distal Clavicle Resection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 219. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery--Acromioplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter-Surgery for impingement syndrome; partial claviclectomy.

Decision rationale: Both the California MTUS guidelines (Shoulder complaint chapter,p.211) and the ODG guidelines recommend that three to six months of conservative care including cortisone injections be given before considering surgery. Documentation does not show this recommendation has been followed. The ODG guidelines point out that acromioplasty provides no clinically important effects over a structured and supervised exercise program. Criteria for partial clavicle resection include imaging findings of severe degenerative joint disease of the AC joint or post traumatic changes. Documentation does not provide imaging findings supporting these criteria. Thus, the requested treatment: Resection of coracoacromial ligament and bursa and possible distal clavicle resection is not medically necessary and appropriate.

Post-op sling purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Procedure.

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.

Medical Clearance CBC, CMP, PT/PTT, HEP Panel, HIV Panel, U/A, EKG & Chest X-ray: 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) Pre-operative testing.

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.