

Case Number:	CM15-0013180		
Date Assigned:	01/30/2015	Date of Injury:	12/04/2012
Decision Date:	05/08/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	01/22/2015

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 50-year-old female who reported an injury on 12/04/2012. The injured worker was reportedly struck in the right upper extremity by a heavy object, causing the injured worker to fall to the ground. The current diagnoses include neck pain, bilateral shoulder pain, left elbow pain, right ankle pain, and right elbow pain. On 12/10/2014, the injured worker presented for an evaluation with complaints of intractable shoulder pain. The injured worker also reported intractable neck pain and bilateral elbow pain. It was noted that the injured worker was utilizing omeprazole, ibuprofen, and Flexeril. Upon examination of the left shoulder, there was evidence of tenderness over the anterior shoulder region, subacromial space, and acromioclavicular joint. There was 122 degrees flexion, 40 degrees extension, 106 degrees abduction, 40 degrees adduction, 90 degrees external rotation, and 22 degrees internal rotation. There was positive Neer's and Hawkins sign, as well as positive cross chest and positive AC joint compression tests. Recommendations at that time included a subacromial decompression of the left shoulder with distal claviclectomy. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic acromioplasty with distal claviclectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 209-210.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. Surgery for impingement syndrome is usually arthroscopic decompression. Conservative care including cortisone injections can be carried out for 3 to 6 months prior to surgery. In this case, it is noted that the injured worker has received conservative treatment in the form of activity modification, medication management, physical therapy, and injections. However, there were no official imaging studies provided for this review. Therefore, the current request is not medically appropriate at this time.

(Associated surgical services) Cold therapy 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 services) CPM Machine: 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.

Pain pump: Marcaine: 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.

