

Case Number:	CM15-0161093		
Date Assigned:	09/03/2015	Date of Injury:	04/18/2014
Decision Date:	10/21/2015	UR Denial Date:	08/04/2015
Priority:	Standard	Application Received:	08/17/2015

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, Indiana, Oregon
 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 injured worker is a 52 year old female who sustained an industrial fall injury on 04-18-2014. The injured worker was diagnosed with left rotator cuff tear with impingement, left upper extremity bursitis, left elbow sprain and strain and left mild carpal tunnel syndrome. No surgical interventions were documented. Treatment to date has included diagnostic testing with Electromyography (EMG) and Nerve Conduction Velocity (NCV) of the left upper extremity performed on April 23, 2015, conservative measures, physical therapy, brachial splint appliance, electrical muscle stimulation unit and medications. According to the primary treating physician's progress report on May 1, 2015, the injured worker continues to experience left shoulder pain. The injured worker rated her pain level at 4-5 with medications and 9 out of 10 on the pain scale without medications. The injured worker related approximately 6 hours relief with medications. Several documents within the submitted medical records are difficult to decipher. Examination demonstrated tenderness to palpation of the subacromial and acromioclavicular joint with positive impingement signs and limited range of motion with weakness in all planes. The trapezius was noted to have decreased tone and tenderness to palpation. Current medications were listed as Ultram and Anaprox. Treatment plan consists of continuing medication regimen, home exercise program with heat therapy, electrical muscle stimulation unit, possible steroid injections to the left carpal tunnel area and the current request for left arthroscopic shoulder decompression, distal clavicle resection, retro-coracoid decompression, biceps tendon tenodesis, subscapularis tendon repair, pre-operative medical clearance and post-operative physical therapy and durable medical equipment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left arthroscopic shoulder decompression, distal clavicle resection, retrocoracoid decompression, biceps tendon tenodesis, subscapularis tendon repair: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: Based upon the CA MTUS Shoulder Chapter pages 209-210, recommendations are made for surgical consultation when there are red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case the imaging does not demonstrate significant osteoarthritis or clinical exam findings including result for injection to warrant distal clavicle resection. Therefore, the request is not medically necessary.

Pre-op medical clearance: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-op physical therapy x 12: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Home CPM device x 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 cite any medical evidence for its decision.

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

Associated surgical service: Surgi-Stim unit x 90 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Coolcare 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Shoulder immobilizer with abduction pillow: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Pneumatic compression device: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.