MAXIMUS Federal Services

Case Number:	CM15-0186877		
Date Assigned:	09/30/2015	Date of Injury:	06/21/2010
Decision Date:	12/08/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	09/22/2015

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, 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 55-year-old male, who sustained an industrial injury on 6-21-2010. A review of the medical records indicates that the injured worker is undergoing treatment for degenerative joint disease of the left shoulder with subacromial impingement syndrome status postindustrial left shoulder injury. On 7-24-2015, the injured worker reported muscle pain-cramps, stiffness swelling in joints, joint pain, with frequent headaches. The Comprehensive Orthopedic Consultation report dated 7-24-2015, noted the injured worker's medications as Tramadol and Norflex. The left shoulder examination was noted to show decreased range of motion (ROM), severe supraspinatus tenderness, moderate greater tuberosity tenderness, mild biceps tendon tenderness, moderate AC joint tenderness, and subacromial crepitus, with positive AC joint compression test and Impingement I, II, and III tests. An ultrasound study of the left shoulder obtained on 7-9-2015 was noted to reveal acromioclavicular degenerative joint disease and partial thickness supraspinatus tendon tear. The injured worker was noted to be an excellent candidate for left shoulder arthroscopic evaluation, decompression, and possible clavicle resection. Prior treatments have included formal supervised physiotherapy, and various anti-inflammatory medications and analgesic medications. The request for authorization dated 7-24-2015, requested arthroscopic left shoulder evaluation with decompression, possible distal clavicle resection, pre-op medical clearance, pre-op x-ray for the left shoulder, post-op physical therapy, continuous passive motion rental, post-op Surgi-stim unit, post-op cold therapy unit purchase, shoulder immobilizer purchase, and abduction pillow. The Utilization Review (UR) dated 9-22-2015, denied the requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic left shoulder evaluation with decompression: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 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. 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, failure of 4 months of a comprehensive non-surgical management plan has not been demonstrated. Therefore, the request is not medically necessary.

Associated surgical service: Possible distal clavicle resection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter.

Decision rationale: Based upon the CA MTUS/ACOEM Shoulder Chapter, page 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviculectomy, states surgery is indicated for posttraumatic 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, failure of 4 months of a comprehensive non-surgical management plan has not been demonstrated. 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary

Pre-op X-ray for the left shoulder: 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 (12-sessions): 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 service: Continous passive motion (45-day 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

Post-op Surgi-stim unit (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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary

Post-op 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 service: Shoulder immobilizer (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 service: abduction pillow (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