MAXIMUS Federal Services

Case Number:	CM15-0189041		
Date Assigned:	10/01/2015	Date of Injury:	06/26/2014
Decision Date:	12/15/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/25/2015

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 50-year-old, male who sustained a work related injury on 6-26-14. A review of the medical records shows he is being treated for neck, shoulders, low back and hips pain. Treatments have included 6 sessions of acupuncture (no benefit). Current medications include Tylenol #3, Tizanidine, Omeprazole, Doc-Q-Lace, Mirtazapine and Tamsulosin. In the progress notes, the injured worker reports ongoing right shoulder pain which he rates an 8-9 out of 10. On physical exam dated 7-24-15, he has decreased range of motion in right shoulder in all planes. He has greater tuberosity, supraspinatus, biceps tendon, and acromioclavicular joint tenderness to palpation in right shoulder. He has normal strength in right arm. He has decreased distal right arm sensation to light touch. MRI of right shoulder dated 7-1-15 reveals, "There is tendinosis and peritendinitis of the supraspinatus tendon with no rotator cuff tear. There are arthritic changes of the glenohumeral joint and acromioclavicular joint. There is no fracture or dislocation." He is working with modified duty. The treatment plan includes a request for right shoulder surgery and associated services. The Request for Authorization dated 7-24-15 has requests for arthroscopic right shoulder surgery and associated services. In the Utilization Review dated 9-8-15, the requested treatments of arthroscopic right shoulder decompression, distal clavicle resection, rotator cuff and-or labral debridement and associated services are not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Right Shoulder Decompression, Distal Clavicle Resection, Rotator Cuff and/or Labral Debridement: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

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 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, the imaging does not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. There is no evidence of relief with anesthetic injection. Therefore, the request is not medically necessary.

Supervised Post-Op Rehab Therapy 3x4: 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: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

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

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