

Case Number:	CM15-0193455		
Date Assigned:	10/09/2015	Date of Injury:	11/20/2013
Decision Date:	12/21/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	10/01/2015

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:

This injured worker is a 44 year old female who reported an industrial injury on 11-20-2013. Her diagnoses, and or impressions, were noted to include: left shoulder sprain-strain with impingement syndrome with antero-inferior labral tear. No current magnetic imaging studies were noted; left shoulder magnetic resonance imaging was said to be done on 8-29-2014, revealing acromioclavicular degenerative joint disease, impingement along the rotator cuff, supra-spinatus partial thickness tear, and anterior labral tear versus Bankart lesion. Her treatments were noted to include: acupuncture treatments; physical therapy; injection therapy; medication management; and rest from work. The comprehensive orthopedic progress notes of 7-20-2015 reported: evaluation for a 2nd opinion; and ongoing left shoulder pain, rated 8 out of 10, despite 10 visits of physical therapy, 1 Cortisone injection, 10 sessions of acupuncture treatments, various medications, and the passage of time. The objective findings were noted to include: no apparent distress; severe left shoulder tenderness to the supra-spinatus; moderate tenderness to the left greater tuberosity and left "AC" joint; positive left sub-acromial crepitus; decreased left shoulder range-of-motion; decreased left muscle strength, affected by pain; and positive left "AC" joint compression test, and impingement I, II and III tests; and that she was an excellent candidate for arthroscopic left shoulder evaluation, arthroscopic labral repair versus debridement, sub-acromial decompression, and distal clavicle resection, followed by 3 months of physical therapy before reaching a point of maximum medical benefit from orthopedic treatment. The physician's request for treatments were noted to include: the described surgery with pre-operative medical clearance; supervised post-operative rehabilitative therapy designed to reduce

pain-swelling, and regain motion-strength; a home continuous passive motion (CPM) device for initial period of 45 days, to assist in restoring range-of-motion; a shoulder immobilizer with abduction pillow for support; and a Surgi-Stim unit for an initial period of 90 days, with a Cool-care cold therapy Unit, to assist with managing post-operative swelling, edema and pain. The Request for Authorization, dated 7-20-2015, was noted to include: arthroscopic left shoulder evaluation, arthroscopic labral repair versus debridement, sub-acromial decompression and distal clavicle resection; pre-operative medical clearance; supervised post-operative rehabilitative therapy, 3 per week for 4 weeks; home continuous passive motion (CPM) device, for an initial period of 45 days; Surgi-Stim unit, for an initial period of 90 days; (illegible) cold therapy unit; shoulder immobilizer with abduction pillow. The Utilization Review of 9-16-2015 non-certified the requests for: left shoulder arthroscopic surgery evaluation, labral repair versus debridement, sub-acromial decompression and distal clavicle resection; pre-operative medical clearance; and post-surgical supervised rehabilitative therapy, 3 x 4 (12); the rental of a Surgi-Stim unit x 90 days; Cool Care Cold therapy unit; shoulder immobilizer with abduction pillow; and the rental of a home continuous passive motion device, x 45 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic evaluation, labral repair versus debridement, subacromial decompression and 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: 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 Pgs. 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 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 to warrant distal clavicle resection. It is also not clear if the AC joint has been injected. Therefore the request is not medically necessary.

12 supervised post-operative rehabilitative therapy 3x4: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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

Associated surgical services: Surgi stim unit rental x90 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Associated surgical services: Cool care cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Associated surgical services: Shoulder immobilizer with abduction pillow: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Associated surgical services: Home continuous passive motion device rental x45 days:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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