MAXIMUS Federal Services

Case Number:	CM15-0047303		
Date Assigned:	03/19/2015	Date of Injury:	05/24/2007
Decision Date:	05/12/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	03/12/2015

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 64-year-old female who reported an injury on 05/24/2007. The mechanism of injury was repetitive use. Diagnostic study tests were not provided. Her surgical history was noted to include surgical decompression of the right peroneal and posterior tibial nerves, performed on 05/23/2014. During the assessment on 11/24/2014, the injured worker complained of significant right shoulder pain. She reported weakness in the right shoulder, as well as night pain and difficulty moving, especially overhead. The physical examination of the right shoulder revealed forward flexion of 175 degrees, abduction of 175 degrees, internal rotation to T6 of 80 degrees, and external rotation of 60 degrees. The active ranges of motion revealed forward flexion of 100 degrees, abduction of 95 degrees, internal rotation to the lower thoracic spine, and external rotation of 50 degrees. There was a positive Hawkins and Neer's, as well as positive external rotation abduction tests of the right shoulder. The right shoulder acromioclavicular joint was nontender to palpation. The treatment plan was to request authorization for right shoulder diagnostic arthroscopy, repair or debridement of any structural as indicated, subacromial decompression, partial acromioplasty, possible rotator cuff repair, and possible biceps tenodesis. The rationale for the request was to aid in the continued significant right shoulder pain. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient right shoulder arthroscopy, repair or debridement of any structural as indication; SAD partial acromioplasty; Possible rotater cuff repair; Possible biceps tenodesis if indicated: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: The request for outpatient right shoulder arthroscopy, repair or debridement of any structural as indication; SAD partial acromioplasty; possible rotator cuff repair; possible biceps tenodesis is not medically necessary. The California MTUS ACOEM Guidelines state that rotator cuff tears are frequently partial thickness or smaller full thickness tears. For partial thickness rotator cuff tears and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. However, there was no documentation the injured worker had failed 3 months of conservative treatment. Additionally, clinical imaging findings revealing positive evidence of a deficit in the rotator cuff were not provided for review. As such, the request is not medically necessary.

Associated surgical service: Surgical Assistant: 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.

Preoperative 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.

Postoperarive cryotherapy 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.

Postoperative shoulder immobilizer/sling: 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.

Twelve (12) postoperative physical therapy 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.