

Case Number:	CM15-0049828		
Date Assigned:	03/23/2015	Date of Injury:	03/05/2013
Decision Date:	05/12/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/16/2015

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 male who reported an injury on 03/05/2013. On 05/29/2013, the injured worker underwent an MRI of the left shoulder which showed a SLAP 2 lesion, very mild degenerative changes involving the acromioclavicular joint, a small benign cyst lesion involving the superolateral aspect of the humeral head, and no evidence of a rotator cuff tear. On 02/10/2015, he presented for a followup evaluation regarding his work related injury. He complained of neck pain on the left side due to his inability to raise his arm. On examination, he walked without difficulties or limp and was able to ascend on and off an examination table. There was no evidence of radiculopathy, myelopathy, or peripheral nerve, motor, or sensory deficits. Sensation was intact, deep tendon reflexes were intact, and there were no Hoffman's or Babinski's signs. The left shoulder showed global tenderness with mild evidence of scapulothoracic dyskinesia. The Hawkins and Neer's test on this side were positive, as were cross arm abduction tests. Motor strength testing of the supraspinatus and external rotators revealed 5-/5 strength with associated mild pain. There was also mild acromioclavicular joint pain to palpation. Range of motion was documented as forward flexion 155 degrees, external rotation at 90 degrees, internal rotation occupational therapy the L5 with pain, and abduction to 175 degrees. He was diagnosed with a partial thickness rotator cuff tear with reinjury status post successful rotator cuff repair and SLAP repair surgery. It was stated that the injured worker had evidence of adhesive capsulitis and it was recommended that he undergo a diagnostic arthroscopy and manipulation under anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic arthroscopy and manipulation left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Diagnostic Arthroscopy.

Decision rationale: According to the California ACOEM Guidelines, a referral for surgical consultation may be indicated for those who have red flag conditions, activity limitations for more than 4 months, failure to increase range of motion and strength of the musculature around the shoulder, clear clinical imaging evidence of a lesion that has been shown to benefit from surgical repair. No recent imaging studies were provided for review to show that the injured worker has a lesion that has been shown to benefit from surgical repair. Also, there is a lack of documentation showing that he has tried and failed an adequate trial of conservative care such as physical therapy to support the requested procedure. Therefore, this request is not medically necessary.

Post-operative physical therapy 2x6 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.

Cryo unit 7 day rental, 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.

Pre-operative labs and EKG: 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.