

Case Number:	CM15-0052905		
Date Assigned:	03/26/2015	Date of Injury:	07/01/2012
Decision Date:	05/04/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/20/2015

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: Illinois, California, Texas

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 35-year-old female who sustained an industrial injury on 7/01/12. Injury occurred during an altercation while she was trying to restrain a juvenile. The 1/19/15 orthopedic report indicated that the patient had persistent right shoulder pain, rated grade 8-9/10. She had failed aggressive conservative measures including physical therapy and two corticosteroid injections. Right shoulder range of motion was documented as flexion 155, abduction 145, extension 40, adduction 40, external rotation 90, and internal rotation 60 degrees. Physical exam documented severe supraspinatus tenderness, moderate greater tuberosity and AC joint tenderness, and mild biceps tendon tenderness. There was positive subacromial crepitus and global 4/5 shoulder weakness. AC joint compression and impingement tests were positive. The diagnosis was right shoulder impingement syndrome, status post right shoulder sprain/strain. MRI showed subacromial impingement but no rotator cuff or labral tear. The treatment plan included right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, distal clavicle resection, possible rotator cuff debridement and or repair as indicated. Associated surgical services were requested for Coolcare cold therapy unit, Surgi-Stim unit initial 90 days, home continuous passive motion (CPM) device initial 90 days, supervised post-operative rehabilitation therapy twelve (12) sessions, and standard pre-operative medical clearance. The 2/24/15 utilization review non-certified the request for right shoulder surgery and associated surgical items based on an absence of information to support the medical necessity of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

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.

Surgi-Stim Unit; Initial 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.

Home Continuous Passive Motion (CPM) Device; initial 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous passive motion (CPM).

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

Supervised Post - Operative Rehabilitation 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: Standard Pre-Operative 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.

Right Shoulder Arthroscopic Evaluation, Arthroscopic Subacromial Decompression, Distal Clavicle Resection, Possible Rotator Cuff Debridement and/or Repair as indicated: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for rotator cuff repair; Surgery for impingement syndrome; Partial claviclelectomy.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Conventional x-rays, AP, and true lateral or axillary view. An MRI, ultrasound, or arthrogram showing, positive evidence of impingement are required. Guideline criteria for partial claviclelectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have not been met. This patient presents with persistent right shoulder pain. Clinical exam findings are consistent with a diagnosis of impingement. However, there is no radiographic or imaging evidence provided for this review to evidence impingement and AC joint pathology. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. In the absence of this documentation, medical necessity cannot be established. Therefore, this request is not medically necessary.