

Case Number:	CM15-0064880		
Date Assigned:	04/20/2015	Date of Injury:	06/10/2014
Decision Date:	07/23/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/07/2015

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: New York
Certification(s)/Specialty: Neurological 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 60 year old male, who sustained an industrial/work injury on 6/10/14. He reported initial complaints of right shoulder pain. The injured worker was diagnosed as having rotator cuff tear of the right shoulder, herniated nucleus pulposus of the cervical spine, carpal tunnel syndrome, and radiculopathy. Treatment to date has included medication, physical therapy, and steroid injection to right shoulder. MRI results were reported on 1/6/15. Electromyography and nerve conduction velocity test (EMG/NCV) was done on 1/12/15. Currently, the injured worker complains of increased pain in the right shoulder that was aggravated by overhead lifting/reaching and rated at 7/10. Per the primary treating physician's progress report (PR-2) on 3/4/15, examination noted tenderness in the right anterior acromial area. JAMAR grip dynamometer strength readings revealed 24/20/24 on the right and 60/58/60 on the left. Current plan of care included a right shoulder arthroscopy due to continued pain and failed conservative treatment. The requested treatments include right shoulder arthroscopy, associated surgical service: physical therapy, associated surgical service: Micro Cool Unit, associated surgical service: Continuous Passive Motion (CPM) machine, associated surgical service: Vena Pro Pneumatic Compression Machine, associated surgical service: Home Therapy Kit, associated surgical service: Ultra sling, pre-operative History and Physical, pre-operative EKG, pre-operative Chest X-Ray, and pre-operative lab work up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 209-211.

Decision rationale: California MTUS guidelines do recommend shoulder arthroscopy if there is clear clinical and imaging evidence of a lesion shown to respond both in the short and long term to surgical repair. Documentation does not show such evidence. The patient's MRI does not show a full thickness tear. Guidelines also recommend a home exercise program as part of conservative care. Documentation does not provide evidence of this. The requested right shoulder arthroscopy is not medically necessary and appropriate.

Associated surgical service: Physical Therapy 2 times a week for 4 weeks: 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: Micro Cool Unit x 3 weeks: 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: Continuous Passive Motion x 4 weeks: 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), Shoulder, Continuous passive motion (CPM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Shoulder Chapter, Continuous Passive motion.

Decision rationale: The ODG guidelines do not recommend Continuous Passive motion (CPM) for shoulder rotator cuff problems. They noted from 11 trials of adding CPM to postoperative physical therapy that there was moderate evidence for no difference in function and pain. One study found no difference in range of motion or strength.

Associated surgical service: Vena Pro Pneumatic Compression Machine: 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 Therapy Kit: 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: Ultrasling: 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 History and Physical: 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 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.

Pre-Operative Chest X-Ray: 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 Lab Work Up: 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.