MAXIMUS Federal Services

Case Number:	CM15-0067992		
Date Assigned:	04/15/2015	Date of Injury:	08/06/2013
Decision Date:	07/16/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/09/2015

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 45 year old male who sustained an industrial injury on 8/6/2013. His diagnoses, and/or impressions, include: right rotator cuff rupture with repair x 2 (12/10/13 & 12/20/14) - unsuccessful; right impingement with shoulder pain; and right brachial plexus lesion, supra-scapular nerve with pain. A recent magnetic resonance imaging study of the right shoulder is stated to have been done on 10/20/2015. X-rays, an electromyogram, and nerve conduction studies were noted to have been done on 3/12/2015. His treatments have included 2 prior shoulder surgeries that were unsuccessful. The progress notes of 3/19/2015 noted complaints of continued weakness about the shoulder, and discomfort with associated arm use; and that he had been returned to full work duties. The physician's requests for treatments were noted to include a new and novel approach of right shoulder arthroscopy stabilization surgery (multiple procedures), along with a surgical assistant, post-operative physical therapy, post-operative cold therapy unit, post-operative sling - for immobilization, and a Breg exercise kit with pulleys and bands which will substitute for extensive formal physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY WITH POSSIBLE ROTATOR CUFF REPAIR, CAPSULORHAPHY, SUPERIOR CAPSULE RECONSTRUCTION, EXTENSIVE, DEBRIDEMENT AND POSSIBLE BICEPS TENODESIS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212.

Decision rationale: The California MTUS guidelines note surgical consultation may be indicated if there is clear clinical and imaging evidence of a lesion that has been shown to benefit, in both short and long term, from surgical repair. The novel recommendations of the provider do not provide sufficient evidence of this benefit. The guidelines do not recommend surgery for mild symptoms or those which do not significantly limit function. Documentation shows this patient is back at work. The requested treatment: RIGHT SHOULDER ARTHROSCOPY WITH POSSIBLE ROTATOR CUFF REPAIR, CAPSULORHAPHY, SUPERIOR CAPSULE RECONSTRUCTION, EXTENSIVE, DEBRIDEMENT AND POSSIBLE BICEPS TENODESIS is NOT Medically necessary and appropriate.

ASSOCIATED SURGICAL SERVICES -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.

ASSOCIATED SURGICAL SERVICES-POSTOPERATIVE 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.

ASSOCIATED SURGICAL SERVICES- POSTOPERATIVE HOME EXERCISE 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.

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.

ASSOCIATED SURGICAL SERVICES- POSTOPERATIVE PHYSICAL 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.