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| Case Number: | CM15-0069071 | | |
| Date Assigned: | 04/27/2015 | Date of Injury: | 11/20/2003 |
| Decision Date: | 07/31/2015 | UR Denial Date: | 04/09/2015 |
| Priority: | Standard | Application Received: | 04/10/2015 |

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 49 year old female, who sustained an industrial injury on 11/20/03. She reported neck pain with paresthesia, right hand weakness, left hand pain, and left had weakness. The injured worker was diagnosed as having left rotator cuff tear, impingement syndrome status post bilateral left arthroscopic acromioplasty and distal claviclectomy, cervical radiculopathy status post anterior discectomy and fusion at C6-7, carpal tunnel syndrome status post bilateral endoscopic carpal tunnel release, bilateral cubital tunnel syndrome, and adhesive capsulitis of the right shoulder. Treatment to date has included medications and occupational therapy. Currently, the injured worker complains of left shoulder pain, left hand pain, and right shoulder pain. The treating physician requested authorization for left shoulder arthroscopic revision acromioplasty, removal of distal clavicle ossicle and rotator cuff repair. Other requests included 12 post- operative physical therapy sessions, purchase of a cold therapy unit, continuous passive motion machine 21 day rental, purchase of a pain pump, and 5 bottles of Sprox spray.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic revision acromioplasty, removal of distal clavicle ossicle and rotator cuff repair: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11.

Decision rationale: The California MTUS guidelines indicate that for surgical consideration the patient should have clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. Documentation does not provide this evidence. The guidelines indicate 82-86% success rate for rotator cuff tears with conservative treatment. The requested treatment: Left shoulder arthroscopic revision acromioplasty, removal of distal clavicle ossicle and rotator cuff repair is not medically necessary and appropriate.

Postoperative physical therapy, twelve 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: Purchase of a 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 Service: CPM machine, 21 day rental: 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: Purchase of a pain pump: 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: Shoulder brace: 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.

Five bottles of Sprix Spray: 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.