

Case Number:	CM15-0071867		
Date Assigned:	04/22/2015	Date of Injury:	04/03/2014
Decision Date:	08/04/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/15/2015

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:

This injured worker is a 66-year-old male who sustained an industrial injury on 4/3/14. Injury occurred when he slipped and fell on ice, coming off a ladder with tools and pipe in his hand, and landed on his right side. Injuries were reported to the right shoulder, right hand, and low back. Past medical history was positive for hypertension. The 5/6/14 right shoulder MRI impression documented appreciable degenerative hypertrophy of the acromioclavicular (AC) joint. There were osteophytic changes along the undersurface of the distal clavicle with resultant moderate to appreciable compromise of the subacromial subdeltoid bursa. There was a partial tear at the tendinous insertion of the supraspinatus tendon with no evidence for full thickness tear of retraction. There was small joint effusion and a small amount of fluid in the subcoracoid bursa. The biceps tendon had a normal course and morphology. The glenohumeral joint was intact without evidence for chondromalacia. The 10/23/14 right shoulder x-rays documented degenerative change at the acromioclavicular joint. The 3/20/15 treating physician report cited constant grade 8/10 right shoulder pain radiating down to the upper extremity to the fingers. He was unable to reach overhead and pain was worse with lifting, pulling, and moving the right arm. He reported he was unable to sleep on the right shoulder and had weakness. Conservative treatment had included 24 visits of chiropractic treatment and physical therapy without relief. Medications had included Ultra and Celexa with some benefit, and Flexeril and Naprosyn with no benefit. He did not wish to have injections. He was off work and significantly limited in activities of daily living. Physical exam documented shoulder range of motion (right/left) as follows: abduction 90/107, external rotation 60/90, internal rotation 65/55, and extension 25/25.

There was 5-5 abduction and external rotation strength. There was positive impingement sign bilaterally, and positive Hawkin's, Speed, and cross arm tests on the right. There was tenderness along the rotator cuff, biceps tendon, and AC joint on the right. Fluoroscopy of the right shoulder was performed and showed spurring at the inferior AC joint, type II acromion, and 2 mm of articular surface remaining. The diagnosis included right shoulder impingement, rotator cuff strain, bicipital tendinitis, and AC joint inflammation. Authorization was requested for right shoulder arthroscopy with decompression, operative Mumford procedure, and evaluation of biceps tendons, labrum, and rotator cuff with repair and associated surgical requests. The 4/6/15 utilization review non-certified the right shoulder operative arthroscopy with decompression, Mumford procedure, and evaluation of biceps tendons, labrum, and rotator cuff with repair, and associated surgical requests, as there was no evidence of 3-6 months of conservative treatment or night pain, or documentation of response to physical therapy and injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Operative Arthroscopy with Decompression, Modified Mumford Procedure, and Evaluation Of Biceps Tendon, Labrum and Rotator Cuff with Repair:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, 208-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for impingement syndrome; Partial claviclectomy.

Decision rationale: Despite multiple quotes from the California MTUS guidelines, the provider does not provide a copy of the radiologist's interpretation of the shoulder MRI scan, nor copies of the physical therapist's notes. The guidelines recommend surgery for cases where clear clinical, imaging and electrophysiological evidence is provided showing the presence of a lesion known to respond both in the short and long term from surgical repair. For conservative therapy for impingement syndromes, the California MTUS guidelines recommend a program of muscle strengthening. Details of such a program are not found. The requested treatment of right shoulder operative arthroscopy with decompression, modified Mumford procedure, and evaluation of biceps tendon, labrum and rotator cuff with repair is not medically necessary and appropriate.

Pre-Operative History & 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.

Associates Surgical Service: Polar Care For 21 Days Rental: 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 flow cryotherapy.

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

Associates Surgical Service: Shoulder Immobilizer: 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.

Associates Surgical Service: IF of Muscle Stimulator (Conductive Garment): 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: Hot and Cold Wrap: 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 CBC, BMP: 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.