

Case Number:	CM15-0087602		
Date Assigned:	05/11/2015	Date of Injury:	12/10/2013
Decision Date:	07/15/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	05/07/2015

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: Minnesota, Florida

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 59-year-old male who sustained an industrial injury on 12/10/13. The injured worker was diagnosed as having left shoulder partial thickness rotator cuff tear, left shoulder status post arthroscopic subacromial decompression with partial acromioplasty and bursectomy, diagnostic arthroscopy of the glenohumeral joint, left shoulder degenerative changes noted over the acromioclavicular joint per magnetic resonance imaging and left shoulder adhesive capsulitis status post arthroscopic surgery. Currently, the injured worker was with complaints of left shoulder discomfort. Previous treatments included left shoulder arthroscopic surgery, home exercise program, wrist brace, and physical therapy. Previous diagnostic studies included a magnetic resonance imaging. Physical examination was notable for left shoulder tenderness to palpation to the anterior aspect of the left shoulder and left upper trapezius and painful range of motion. The plan of care was for surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Assistant Surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physicians as Assistants at Surgery, 2007.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Surgeons, Assistant Surgeons 2013.

Decision rationale: The requested surgical procedure qualifies for the need of an assistant surgeon. Therefore, the request is supported and medical necessary.

Associated Surgical Service: Cold Therapy Unit (90-days): 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), Treatment Index, 20th edition (2015 Web), Shoulder Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy for the shoulder following arthroscopic surgery. The general period of use is 7 days. The request as stated is for 90 days, which is not supported. Therefore, the request is not medically necessary.

Associated Surgical Service: E-Stim (90-days): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 20th edition (2015 Web), Shoulder Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Electrical Stimulation, Neuromuscular Electrical Stimulation Page(s): s 118 and 121.

Decision rationale: Interferential Current Stimulation is not recommended by the Chronic Pain Medical Treatment Guidelines, as it is not effective. Neuromuscular stimulation is recommended for stroke rehab. Therefore, the request is not supported and is not medically necessary.

Associated Surgical Service: Large Abduction Pillow: 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), Treatment Index, 20th edition (2015 Web), Shoulder Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Post-operative abduction pillow sling.

Decision rationale: The Official Disability Guidelines do not recommend abduction pillow slings for arthroscopic subacromial decompression or rotator cuff repairs. It is only indicated for open repairs of large and massive rotator cuff tears as it takes the tension off the repair. Therefore, the request is not supported and is not medically necessary.

Associated Surgical Service: Continuous Passive Motion Unit (45-days): 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), Treatment Index, 20th edition (2015 Web), Shoulder Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous Passive Motion.

Decision rationale: ODG guidelines recommend shoulder CPM for adhesive capsulitis. The general period of use is 5 days a week for 4 weeks (20 days). The initial request for CPM was for 45 days and it was modified by UR to 20 days. The 20 days of use would be appropriate and medically necessary. However, the request for 45 days exceeds the guideline recommendations and is not supported and the medical necessity has not been substantiated. Therefore, the request for Continuous Passive Motion Unit (45 days) is not medically necessary and appropriate.