MAXIMUS Federal Services

Case Number:	CM14-0025942		
Date Assigned:	07/18/2014	Date of Injury:	02/12/2013
Decision Date:	08/15/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/28/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 37-year-old gentleman who sustained bilateral shoulder injuries on February 12, 2013. Specific to the claimant's left shoulder, a progress report dated April 11, 2014, describes continued complaints of shoulder pain. Physical examination showed restricted motion with flexion and abduction, positive impingement signs and tenderness to palpation at the acromioclavicular joint. An April 14, 2014, MRI report shows acromioclavicular joint space narrowing with impingement, subacromial bursitis and undersurface inflammation of the supraspinatus but no tearing. The claimant was diagnosed with impingement syndrome. The records available for review state that the claimant underwent a prior course of physical therapy and was treated with an injection; however, the date of the injection and any conservative measures employed in the past two to three months were not noted. This request is for: shoulder arthroscopy, subacromial decompression, rotator cuff repair and Mumford procedure; preoperative medical assessment; eight sessions of post-operative physical therapy; a 14-day rental of a cold therapy unit; a 14-day rental of a interferential unit; the 30-day, postoperative use of a CPM device; the four-day postoperative use of a pain pump; two assistant surgeons; Norco; Xolida 2% pain relief cream; Enova 10% pain relief cream; and an ultrasling for post-operative use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy with debridement rotator cuff repair, SAD Acromioplasty, Mumford: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter Surgery for Impingement.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: Based on California MTUS ACOEM Guidelines, surgical intervention for left shoulder arthroscopy with debridement rotator cuff repair, SAD acromioplasty, and Mumford would not be indicated. In this case, the request includes a rotator cuff repair, yet the MRI report does not reveal any rotator cuff pathology. ACOEM Guidelines recommend rotator cuff repair for significant tears that impair activities. Relating to the diagnosis of impingement, the reviewed records contain no documentation of a trial of conservative measures over the past three to six months, as would be required under ACOEM Guidelines. For these reasons, this request would not be supported as medically necessary.

Pre-op medical Clearance - H&P, CMP CBC, PT, PTT Urinalysis, EKG Chest X-rays:

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 Independent Medical Examinations and Consultations, page 127 Citation(s): Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 127 Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision) - pp. 503.

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

8 Physical therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Cold Therapy unit 14 days rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205,555-556.

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

IF unit 14 days post op: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118,120.

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

CPM machine 30 day post op: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure -Continuous passive motion (CPM).

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

Pain Pump 4 days post op: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter Postoperative Pump.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure -Postoperative pain pump.

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

2 assistant surgeons: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopedic Surgeons Position Statement Reimbursement of the First Assistant Surgeon in Orthopedics.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Milliman Care Guidelines 18th edition: assistant surgeonAssistant Surgeon Guidelines (Codes 29355 to 29901) CPTÂ® Y/N Description 29827 N Arthroscopy, shoulder, surgical; with rotator cuff repair.

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

Norco quantity and strength not specified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids-Criteria For Use Page(s): 76-80.

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

Xolida 2% pain relief cream: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Enova Rx-Ibubrophen 10% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-115.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Ultra Sling: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure -Postoperative abduction pillow sling.

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