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| Case Number: | CM14-0082019 | | |
| Date Assigned: | 08/08/2014 | Date of Injury: | 05/13/2010 |
| Decision Date: | 05/11/2015 | UR Denial Date: | 05/29/2014 |
| Priority: | Standard | Application Received: | 06/03/2014 |

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. 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 66-year-old male who reported an injury on 05/13/2010. The mechanism of injury was not specifically stated. The injured worker is current diagnoses as status post left shoulder arthroscopy on 03/23/2011. The injured worker presented on 08/12/2014 for a follow-up evaluation. It was noted that the injured worker was not working due to temporary total disability. Upon examination of the left shoulder, there was tenderness to palpation over the subacromial region and acromioclavicular joint, subacromial crepitus, positive impingement and cross arm test, 135 degree flexion, 35 degree extension, 142 degree abduction, 35 degree adduction, 55 degree internal rotation, 59 degree external rotation and 4/5 muscle weakness. Recommendations at that time included a repeat shoulder arthroscopy. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Left Shoulder Revision, Decompression, Distal Clavicle Resection, Retrocoracoid Decompression and Labral and Cuff Debridement as Indicated: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs and clear clinical and imaging evidence of a lesion. In this case, there was no documentation of an exhaustion of any recent conservative treatment for the left shoulder. It was noted that the injured worker was treated postoperatively in 2013. In addition, there were no official imaging studies provided for this review. Given the above, the request is not medically appropriate.

Pre-Operative Clearance: 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.

Post-Operative 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.

CPM machine (45-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.

Coolcare 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.

SurgiStim Unit (90-day rental, if providing continuing functional and symptomatic benefit at 90 days use, the purchase of the 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.