

Case Number:	CM15-0006511		
Date Assigned:	01/26/2015	Date of Injury:	10/31/2014
Decision Date:	03/26/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	01/12/2015

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 63 year old male, who sustained an industrial injury on 10/31/2014. He has reported subsequent back and right shoulder pain and was diagnosed with overuse syndrome, tendonitis of the right shoulder and rule out shoulder internal derangement. Treatment to date has included oral pain medication, application of heat and physical therapy. In a progress note dated for 12/05/2014, the injured worker was noted to report continued significant 8/10 right shoulder pain with inability to sleep on the right side. An MRI of the right shoulder was performed on 12/03/2014 and showed post operative changes of prior rotator cuff surgery with a 5 mm fluid filled gap above the prior surgery consistent with limited distal rotator cuff tear and subacromial bursa secondary to subacromial bursitis. The physician noted that the injured worker was being referred to Ortho for consult and had an appointment scheduled for 12/12/2014. A request for authorization of right shoulder acromioplasty & distal clavicle resection, shoulder immobilizer, cold therapy unit, continuous passive motions and pre-operative clearance was submitted by the Orthopedist. Although the Utilization Review physician noted that the 12/12/2014 orthopedic visit note was reviewed, this document was not found in the medical record. On 01/06/2015, Utilization Review non-certified requests for right shoulder acromioplasty & distal clavicle resection with RCR, shoulder immobilizer, cold therapy unit, continuous passive motion and pre-op clearance noting that physical examination of the cervical spine, right shoulder and right upper extremity and neurologic examination was not included in the documentation and that documentation of at least three months of conservative therapy was not included. MTUS, ACOEM and ODG guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder acromioplasty & distalclavical resection with RCR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder Chapter-Surgery for impingement syndrome

Decision rationale: The ODG guidelines recommend acromioplasty for acromial impingement syndrome after at least 3-6 months of conservative care. Documentation shows this much time has not elapsed. The procedure is not recommended for those who have no limitations of activities. Documentation does not describe the degree of limitations. The ODG guidelines also does not recommend the procedure in conjunction with repair of a full thickness rotator cuff tear. Therefore, the requested treatment: right shoulder acromioplasty & distal clavical resection with RCR is not medically necessary and appropriate.

Post-operative shoulder immobilizer: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: right shoulder acromioplasty & distal clavical resection with RCR is not medically necessary and appropriate. then the post-operative shoulder immobilizer is not medically necessary and appropriate.

Decision rationale: Since the requested treatment: right shoulder acromioplasty & distal clavical resection with RCR is not medically necessary and appropriate. then the post-operative shoulder immobilizer is not medically necessary and appropriate.

Post-operative cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: right shoulder acromioplasty & distal clavical resection with RCR is not medically necessary and appropriate. then the post-operative cold therapy unit is not medically necessary and appropriate.

Decision rationale: Since the requested treatment: right shoulder acromioplasty & distal clavical resection with RCR is not medically necessary and appropriate. then the post-operative cold therapy unit is not medically necessary and appropriate.

Post-operative CPM: 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 Since the requested treatment: right shoulder acromioplasty & distal clavical resection with RCR is not medically necessary and appropriate. then the post-operative CPM is not medically necessary and appropriate.

Decision rationale: Since the requested treatment: right shoulder acromioplasty & distal clavical resection with RCR is not medically necessary and appropriate. then the post-operative CPM is not medically necessary and 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: right shoulder acromioplasty & distal clavical resection with RCR is not medically necessary and appropriate. then the pre-operative clearance is not medically necessary and appropriate.

Decision rationale: Since the requested treatment: right shoulder acromioplasty & distal clavical resection with RCR is not medically necessary and appropriate. then the pre-operative clearance is not medically necessary and appropriate.