MAXIMUS Federal Services

Case Number:	CM15-0174069		
Date Assigned:	09/21/2015	Date of Injury:	07/11/2013
Decision Date:	11/18/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	09/03/2015

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: California
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:

This 60 year old male sustained an industrial injury on 9-12-13. Documentation indicated that the injured worker was receiving treatment for a left shoulder injury. Previous treatment included physical therapy (10 sessions), acupuncture (6 sessions), one Cortisone injection and medications. Magnetic resonance imaging left shoulder (8-12-13) showed supraspinatus tendinosis with no evidence of rotator cuff tear, degenerative hypertrophy of the acromioclavicular joint with inferior osteophyte of the distal clavicle abutting the supraspinatus tendon, biceps tendon tenosynovitis, degenerative joint disease with thin articular cartilage of the humerus and glenoid rim and minimal subscapular bursitis. In a comprehensive orthopedic consultation dated 7-6-15, the injured worker complained of left shoulder pain, rated 6 out of 10 on the visual analog scale. Physical exam was remarkable for left shoulder range of motion: forward flexion 150 degrees, extension 40 degrees, abduction 150 degrees, adduction 40 degrees, external rotation 80 degrees and internal rotation 45 degrees, tenderness to palpation to the supraspinatus tendon, greater tuberosity, biceps tendon and acromial joint with positive subacromial crepitus, 4 out of 5 strength, intact sensation and positive acromial joint compression test and impingement tests 1, 2 and 3. The physician stated that magnetic resonance imaging left shoulder (undated) showed chronic subacromial impingement, acromioclavicular degenerative joint disease and tenosynovitis of the biceps tendon without labral or rotator cuff tear. The physician recommended left shoulder arthroscopic decompression, distal clavicle resection and rotator cuff and or labral debridement with associated surgical services. On 8-14-

15, Utilization Review noncertified a request for left shoulder arthroscopic decompression, distal clavicle resection and rotator cuff and or labral debridement with associated surgical services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic decompression, distal clavicle resection: 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 Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty surgery.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209 and 210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 7/6/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 7/6/15 does not demonstrate evidence satisfying the above criteria. Therefore the request is not medically necessary.

Rotator cuff and/or labral debridement: 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 Shoulder Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209 and 210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. In this case the MRI from 8/12/13 does not demonstrate a surgical lesion such as a high grade or full thickness tear and therefore the request is not medically necessary.

Pre-op medical 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-op supervised rehabilitative therapy, x12: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Service: Home CPM, x 45 days: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Service: Shoulder Immobilizer with abduction pillow: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Service: Surgi-stim unit, x90 days, possible purchase: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Service: Cool care 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Service: DVT/Pneumatic compression device: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.