

Case Number:	CM15-0029999		
Date Assigned:	03/25/2015	Date of Injury:	04/19/2011
Decision Date:	05/11/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	02/18/2015

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, 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 49-year-old female who reported an injury on 04/19/2011. The mechanism of injury was not specifically stated. The current diagnoses include history of industrial injury to the left side of the body; resolved left ankle symptoms; left knee pain; history of left shoulder arthroscopy on 12/20/2011; medial and lateral epicondylitis of the left elbow; left carpal tunnel syndrome; left knee contusion; and bilateral carpal tunnel syndrome. The injured worker presented on 06/24/2014 for a followup evaluation. The injured worker reported ongoing symptoms of the right shoulder. It was noted that the injured worker was status post left carpal tunnel release with left de Quervain's release on 08/22/2013, as well as left shoulder arthroscopy on 12/20/2011. The injured worker had been previously treated with a subacromial injection into the left shoulder without relief of symptoms. Upon examination of the left shoulder, there was a positive Neer and Hawkins sign, tenderness at the bicipital groove, painful range of motion, 90 degree forward flexion and abduction, and well healed arthroscopic portals. Recommendations at that time included a revision left shoulder arthroscopic decompression and debridement for recurrent impingement. There was no Request for Authorization form submitted for review. The unofficial MRI of the left shoulder completed on 08/11/2014 was submitted for review, indicating mild scarring of the subacromial space, tendinosis of the biceps tendon, and evidence of a prior Mumford procedure. There was no evidence of a rotator cuff tear or tendinosis and no evidence of a glenoid labral abnormality or degenerative changes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Re-Do Arthroscopy, Subacromial Decompression, and Debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

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. There is no evidence of a recent attempt at any conservative treatment in the form of active rehabilitation. The latest physician progress report was submitted on 06/24/2014, followed by an updated MRI on 08/11/2014. There was no recent physician progress note following the updated MRI in 08/2014. There was no evidence of a significant functional limitation. Given the above, the request is not medically necessary.

Pre-Operative Internal Medicine 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.

RN Assessment for Post-Operative Wound Care and Home Aid as Needed: 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.

Motorized 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.

DVT 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.

CPM Machine: 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.

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

Pain Pump: 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 x 12 to the Left Shoulder: 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.