

Case Number:	CM15-0031921		
Date Assigned:	03/26/2015	Date of Injury:	01/14/2013
Decision Date:	05/11/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/17/2015

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 51-year-old male who reported an injury on 01/14/2013. The mechanism of injury was due to lifting. His diagnoses include status post right shoulder labral repair with recurrent impingement and re-tear; right shoulder labral tear with anterior instability and impingement. His past treatments include medications, acupuncture, and chiropractic therapy. A right shoulder arthrogram performed on 07/16/2014 revealed posterior changes involving the anterior glenoid consistent with a prior labral repair. There is a re-tear involving the anterior superior glenoid labrum and diffuse degenerative changes involving the entire anterior labrum. On 01/12/2015, the injured worker complained of right shoulder pain with associated popping. The physical examination of the shoulder revealed decreased range of motion, positive relocation test, anterior instability, positive impingement, and weakness with abduction and external rotation. The treatment plan included surgical intervention. On 02/26/2015, the injured worker complained of continued back pain rated 8/10 to 9/10 in severity. The injured worker also noted there is most severe pain in the right lumbosacral area that radiates to the right lower extremity. The physical examination revealed tenderness over the PSIS bilaterally, SI joints, facet joints, and lumbar spinous process. The injured worker also had a positive straight leg raise and positive fabere. A request was received for a right shoulder arthroscopy with possible labral repair with debridement versus repair of partial tear of the rotator cuff tendon and subacromial decompression, preoperative clearance, RN assessment, 12 sessions of postoperative PT, motorized cold therapy unit, CPM machine, abduction pillow, and DVT unit. A rationale was not provided. A Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with Possible Labral Repair with Debridement versus Repair of Partial Tear of Rotator Cuff Tendon and Subacromial Decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

Decision rationale: According to the California MTUS/ACOEM Guidelines, surgical consideration is dependent upon the working or imaging confirmed diagnoses of the present shoulder complaint. The injured worker was noted to have had shoulder complaints on 01/12/2015; however, the physical examination dated 02/26/2015 did not present any physical examination findings in regard to the right shoulder. Furthermore, there is lack of documentation specifying the previous surgical date. Clarification would be needed to compare the previous surgical date to the current diagnostic study provided for review. There was also lack of documentation in regard to conservative care postsurgical for at least 3 to 6 months. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary or appropriate at this time.

Internal Medicine 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.

Registered Nurse Assessment: 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.

12 sessions of Post-Operative Physical Therapy: 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.

Purchase of 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy.

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

Purchase of Continuous Passive Motion Machine: 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 Official Disability Guidelines (ODG) Shoulder, CPM.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, abduction pillow.

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

Purchase of Deep Vein Thrombosis Unit: 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 Official Disability Guidelines (ODG) Shoulder, Compression garments.

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