MAXIMUS Federal Services

Case Number:	CM15-0060030		
Date Assigned:	04/06/2015	Date of Injury:	11/22/2014
Decision Date:	05/29/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	03/30/2015

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 66-year-old male, who sustained an industrial injury on November 12, 2014. The mechanism of injury involved a fall. Diagnoses have included right shoulder impingement and right rotator cuff tear. Treatment to date has included medications, physical therapy, and imaging studies. A progress note dated February 9, 2015 indicates a chief complaint of right shoulder pain. Upon examination, there was 160-degree abduction, 170-degree flexion, 70-degree external rotation, and 30-degree extension. Internal rotation remained restricted at 50 to 60 degrees. The injured worker continued to perform modified work. There was no evidence of sensory or vascular deficit in the affected extremity. Treatment recommendations at that time included surgical intervention. There was no Request for Authorization form submitted for this review. The official MRI of the right shoulder on 01/16/2015 was submitted for review; however, the report is incomplete. There is documentation of moderate degenerative changes of the acromioclavicular joint with moderate synovitis, degenerative changes involving the glenohumeral joint, fluid in the subacromial and subdeltoid bursa, and no evidence of a fracture or dislocation. With regard to the rotator cuff, there was a 1.4 cm full thickness tear noted in the anterior fibers of the supraspinatus located 2.2 cm from the insertion site with mild retraction of the anterior fibers of the supraspinatus.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Right Shoulder Arthroscopy; Possible Arthroscopic Vs. Open Decompression with Acromioplasty; Rotator Cuff Debridement Vs. Repair; Resection of Coracoacromial Ligament and/or Bursa as indicated; Distal Clavicle Resection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder.

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

Decision rationale: The 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 al lesion. Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation. Surgery for impingement syndrome is usually arthroscopic decompression and is not indicated for patients with mild symptoms or those who have no activity limitation. Conservative care, including a cortisone injection, should be carried out for at least 3 to 6 months prior to considering surgery. It is noted that the injured worker has been previously treated with a short course of physical therapy. However, the official imaging study confirms moderate degenerative joint disease along with a retracted supraspinatus and atrophy. The likelihood of success with a simple arthroscopy would be very limited. There is moderate glenohumeral degenerative joint disease with articular cartilage loss and synovial proliferation. Clinical impingement signs are not demonstrated on the physical examination. Given the above, the request cannot be determined as medically necessary in this case.

Assisted Surgeon: 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 (18-sessions, 3 times a week for 6 weeks): 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.

Associated Surgical Service: 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.

Associated Surgical Service: E-Stim Unit (90-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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-Operative Continuous Passive Motion (CPM) Device (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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: Sling with Large 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.