

Case Number:	CM15-0097641		
Date Assigned:	06/19/2015	Date of Injury:	04/07/2011
Decision Date:	09/09/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	05/20/2015

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:

The injured worker is a 37 year old, female who sustained a work related injury on 4/7/11. The diagnoses have included left shoulder impingement and status post continuous trauma left shoulder injury. Treatments have included rest, home exercises, medications, acupuncture, physical therapy and left shoulder cortisone injection. MRI left shoulder from 2/25/15 demonstrates no definitive evidence of labral tear, no evidence of rotator cuff tear or tendinosis. In the PR-2 dated 3/13/15, the injured worker complains of ongoing left shoulder pain. She complains of left shoulder radiating pain down left arm to elbow and fingers. She states this is causing pain in her neck. She rates her pain level a 7-9/10. She describes the pain as dull, achy, burning, stabbing and constant. She has pain that is associated with tenderness, fatigue, numbness and tingling. Shoulder pops and cracks and is radiating. She has decreased range of motion in left shoulder. She has severe supraspinatus tenderness. She has positive impingement tests with left shoulder. The treatment plan includes requests for left shoulder surgery, for preoperative medical clearance, for postoperative physical therapy and for postoperative durable medical equipment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic left shoulder evaluation, decompression, distal clavicle resection and rotator cuff debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery-Acromioplasty, Shoulder (Acute & Chronic): Surgery for Impingement syndrome (2015).

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

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, 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 2/25/15 does not demonstrate a surgical lesion that would benefit from surgical repair. Therefore the determination is for non-certification.

Pre-operative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Preoperative testing.

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

Post-operative rehabilitative therapy sessions (supervised) Qty: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

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

Associated surgical service: Home continuous passive motion (CPM) device for an initial period of 45 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee, Shoulder (Acute & Chronic); Continuous Passive Motion (CPM) (2015).

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.

Associated surgical service: Surgi-Stim unit for an initial period of 90 days:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Electrical stimulation.

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

Associated surgical service: Cool care cold therapy unit:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic): Continuous-flow cryotherapy (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter, Continuous flow cryotherapy.

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

Associated surgical service: Shoulder immobilizer with abduction pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic): Post-operative abduction pillow sling (2015).

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.

