

Case Number:	CM14-0141277		
Date Assigned:	09/10/2014	Date of Injury:	02/23/2004
Decision Date:	10/16/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/02/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 73 year old male who reported an injury on February 23, 2004 to his right shoulder as a result of attempting to cross a canal with a 2x6. The injured worker stepped on the 2x6 when he fell. The injured worker stated he pulled his back resulting in popping sensation. A clinical note dated 09/22/05 indicated the initial injury occurred on 08/19/05. The injured worker was recommended for MRI at that time. The injured worker underwent chiropractic therapy. A clinical note dated 10/31/13 indicated the injured worker continuing with right shoulder pain. The injured worker had decreased range of motion throughout the right shoulder. Tenderness to palpation was identify at the footprint of the right shoulder. The injured worker was recommended for physical therapy. A clinical note dated 05/28/13 indicated the injured worker having inability to raise shoulder above arm above shoulder level. The injured worker demonstrated 90 degrees of right shoulder flexion, 0 degrees of extension, 80 degrees of abduction, 0 degrees of adduction, 20 degrees of internal rotation, and 40 degrees of external rotation. The utilization review dated 12/27/13 resulted in denial for subacromial decompression, 12 post-operative physical therapy sessions, and cold therapy unit as insufficient information was submitted supporting surgical procedure. A clinical note dated 05/06/14 indicated the injured worker utilizing Vicoprofen for pain relief. The injured worker continued with range of motion deficits. The MRI of the right shoulder dated 08/04/14 revealed no evidence of partial full thickness rotator cuff tear. Small focus of fissuring was identified at posterior superior labrum. Moderate partial tearing of the long head of the biceps tendon was identified.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right shoulder arthroscopy, subcromial decompression, Mumford, bicep tedonosis, possible core decompression humeral head: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ACOEM), 2nd Edition, (2004) Shoulder Chapter, Pages 209-11

Decision rationale: The request for right shoulder arthroscopy with subacromial decompression, Mumford, biceps tenodesis, and possible core decompression of humeral head is non-certified. The patient complained of right shoulder pain with associated range of motion deficits. A surgical procedure is indicated for patients who have completed all conservative treatment and imaging studies confirm significant pathology. The MRI of the right shoulder revealed no significant pathology that would warrant a surgical procedure at this time. It is unclear if the patient completed any conservative treatment as clinical records indicate the patient recommended for physical therapy; however, no therapy notes were submitted for review. Given this, the request is not indicated as medically necessary.

12 Post operative physical therapy sessions: Upheld

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

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

Decision rationale: The request for 12 post-operative physical therapy sessions is non-certified. Given the non-certification of the surgery the additional request for post-operative care is non-certified.

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 ODG) Low Back Chapter, Preoperative

Decision rationale: The request for pre-operative medical clearance is non-certified. Given the non-certification of the requested surgery the additional request for pre-operative clearance is rendered non-certified.

Cold Therapy and Immobilizer: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Shoulder Chapter, Postoperative abduction pillow sling

Decision rationale: The request for cold therapy and immobilizer unit is non-certified. The injured worker complained of right shoulder pain with associated range of motion deficits. Use of cold therapy unit and immobilizer unit is indicated as part of post-operative setting following rotator cuff tear. No information was submitted regarding rotator cuff repair at this time. Given this, the request is not indicated as medically necessary.