

Case Number:	CM14-0111759		
Date Assigned:	09/16/2014	Date of Injury:	12/11/2012
Decision Date:	10/20/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/17/2014

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 Orthopedic Surgery and is licensed to practice in California. 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:

This case involves a 66 year old female injured worker who sustained an industrial injury on 12/17/12. The patient is status post a right/left shoulder and right elbow subacromial injection. Exam note 08/27/14 states that the MRI of both shoulders demonstrated tendinosis and a partial tear of the rotator cuff. MRI of the right wrist provides evidence for a partial tear of the TFCC ligament, median nerve neuritis, and ulnar impaction on the wrist as well as CMC joint arthritis of the wrist. Upon physical exam the patient had an abduction of 85' on the right and decreasing. The internal rotation is 75', external rotation is 90', neck flexion is 40', and extension is 20'. The wrist dorsiflexion is 55', and palmar flexion is 60-65'. The patient has weakness when completing the resisted external rotation and abduction. The patient was diagnosed with impingement syndrome bilaterally and bicipital tendinitis. In addition, she has evidence of epicondylitis bilaterally more laterally than medially and more on the right than the left. There is intersection syndrome bilaterally, and the first extensor compartment tenosynovitis due to the patient completing a negative Finelstein's test. It is also noted that the patient has inflammation on both wrists, with a partial tear at the TFCC ulnar attachment, medial nerve neuritis, and carpal trapezial arthritis. Treatment includes an injection in the thumb where the tenderness is present, two thumb splints, physical therapy, and shoulder surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy, decompression, eval of biceps, rotator cuff and labrum:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff repair

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 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. The Official Disability Guidelines (ODG) Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case, the submitted notes from 8/27/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 8/27/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore, the request is not medically necessary.

Pre-Operative Clearance: H & P, CBC, CMP, EKG, Chest X-ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Polar care, 21 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines DME (Durable Medical Equipment).

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Shoulder Immobilizer: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines DME (Durable Medical Equipment).

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.