

Case Number:	CM14-0162892		
Date Assigned:	10/08/2014	Date of Injury:	01/31/2006
Decision Date:	12/30/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	10/03/2014

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 is a 53-year-old female with a documented date of injury on 01/31/08. The medical records provided for review documented current complaints of pain in the left shoulder. The 07/16/14 progress report documented bilateral complaints of shoulder pain, described by the claimant as greater in the right shoulder than the left. Examination revealed no obvious deformity or swelling, 4/5 strength with empty can testing on the left and 4-/5 strength on the right. There was diffuse tenderness to palpation and positive impingement signs. Imaging available for review documents a recent right shoulder MRI scan that showed evidence of full thickness tearing to the distal supraspinatus with tendon retraction and muscle atrophy. The claimant was documented to be status post prior rotator cuff repair procedure to the right shoulder. There is, unfortunately, no documentation of left shoulder imaging available for review. There is no indication of recent treatment other than medication management. At a follow up office visit on 08/12/14, the claimant's right shoulder MRI scan was reviewed and surgery for the "left" shoulder was recommended. There is a current request for a left shoulder arthroscopy with rotator cuff repair in this individual.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy with rotator cuff repair QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder (updated 08/27/2014)

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

Decision rationale: Based on California ACOEM Guidelines, the request for left shoulder arthroscopy and rotator cuff repair is not recommended as medically necessary. The medical records document that the claimant has bilateral shoulder complaints for which only a right shoulder MRI report is available for review. The right shoulder MRI demonstrates recurrent rotator cuff tearing in an individual who had previously undergone surgical repair. There is currently no documentation of imaging to the left shoulder to support full thickness rotator cuff pathology that would necessitate the proposed surgery. There is also limited documentation of conservative treatment to the left shoulder for review. Without documentation of formal imaging demonstrating pathology to the rotator cuff, the acute need of a left shoulder arthroscopy and rotator cuff repair would not be supported.

Post-operative physical therapy 24 visits: Upheld

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

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.

Cold therapy unit QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 08/27/2014) Continuous flow cryotherapy

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.

Home health care three times a week for four hours a day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

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.

Pain Management referral for medication detoxification QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7: Independent Medical Examinations and Consultations page 127

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7 Independent Medical Examinations and Consultations, page 127.

Decision rationale: California ACOEM Guidelines would not support a Pain Management referral for detoxification. The medical records document that the claimant has continued shoulder complaints with an MRI scan demonstrating large recurrent rotator cuff pathology. There is currently no clear documentation as to the claimant's current usage of medications, length of medication use, or inability to wean from medications without need for Pain Management referral. The acute request for Pain Management referral for medication "detoxification" is not supported by current clinical records and would not be indicated.

Ultra Sling QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 08/27/2014) Post operative abduction pillow sling

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.