

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0027637 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 06/27/2011 |
| Decision Date: | 07/25/2014 | UR Denial Date: | 02/18/2014 |
| Priority: | Standard | Application Received: | 03/03/2014 |

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, has a subspecialty in Hand Surgery 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 56-year-old female who reported injury on 06/27/2011. The mechanism of injury was a trip and fall. The injured worker underwent an MRI on 01/19/2014 which revealed a longitudinal defect of the supraspinatus anteriorly at the site of repair. The physician opined this was the patient's baseline in a non watertight repair. The physician further indicated they could not exclude the possibility of a recurring tear. Additionally, there was scarring in the bursa which was also an expected postoperative finding. The injured worker's prior treatments included physical therapy preoperative and postoperative to the procedure on 07/28/2012 of the right shoulder. The physical examination dated 11/21/2013 revealed the injured worker had complaints of right shoulder pain and weakness. The injured worker complained of severe pain and weakness with overhead activities and pain when sleeping. The examination of the right shoulder revealed the injured worker had significant tenderness over the anterior aspect of the shoulder. The injured worker had decreased range of motion in abduction, flexion, internal rotation and external rotation. The injured worker's grip strength on the right hand was 10, 10, 0 and on the left 30, 30, 20. The motor strength in the supraspinatus was 4+/5 on the right. The patient had a positive impingement 1 and impingement 2 test as well as a positive drop arm test. The injured worker underwent an x-ray of the right shoulder and humerus which showed spurring on the undersurface of the acromion as well as the acromioclavicular joint. The diagnosis included clinical evidence of a possible rotator cuff tear of the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER WITH REVISION OF ROTATOR CUFF REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-211.

Decision rationale: The ACOEM Guidelines indicate that surgical consultations and treatment may be appropriate for injured workers who have red flag conditions, activity limitations for more than 4 months plus the existence of a surgical lesion, the failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus the existence of a surgical lesion upon imaging and objective physical examination. Additionally, for partial thickness rotator cuff tears and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative care for 3 months. The clinical documentation submitted for review indicated the injured worker underwent prior physical therapy, surgical intervention and postoperative physical therapy in 2012. However, there was a lack of documentation of recent conservative care and imaging to support the necessity for surgery. Given the above, the request for right shoulder with revision of rotator cuff repair is not medically necessary.

POSTOP PHYSICAL THERAPY 3 TIMES A WEEK X 4 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.

MEDICAL CLEARANCE: 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.

POSTOP COLD THERAPY UNIT 7 DAY RENTAL: 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.

PAIN PUMP AND SHOULDER IMMOBILIZER PURCHASE: 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.