

Case Number:	CM14-0057612		
Date Assigned:	08/08/2014	Date of Injury:	06/14/2013
Decision Date:	09/17/2014	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/28/2014

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:

A 38-year-old female with an industrial injury reported on June 14, 2013. Reports states the claimant sustained a slip and fall landing on her right shoulder. Exam note from March 19, 2014 demonstrates right shoulder pain and weakness. Report states the claimant uses Ultracet and tramadol for pain relief. Range of motion of the right shoulder is noted to be 100 forward flexion, 50 of internal rotation, 60 of external rotation and 100 of abduction. The report states that the claimant has 4/5 rotator cuff strength. It is noted that the patient has a positive arm test, a positive Hawkins test, positive Neer test and positive empty can test. There is mild tenderness along the paraspinal muscles, more on the right than left. MRI of the right shoulder from December 13, 2013 demonstrates mild supraspinatus and infraspinatus tendinosis without discrete tear. There is mild labral fraying superiorly, distal clavicle mid subchondral cystic change which is either degenerative or posttraumatic. Review of the records demonstrates no documentation of physical therapy or response to cortisone injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with subacromial decompression repair of the rotator cuff and debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter - Surgery Indications for Impingement Syndrome.

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) Surgery for Rotator Cuff Repair.

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. The 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 3/19/14 do not demonstrate 4 months of failure of activity modification. The physical exam does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. There is no evidence of rotator cuff tear in the MRI report from 12/13/13 to satisfy the guidelines. Therefore the determination is for non-certification for the requested procedure.

Physical Therapy 2 x week x 6 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.

Polar Care: 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.

Assistant surgeon: 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.

Ultra Sling: 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.

Pre-operative 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.