

Case Number:	CM14-0048089		
Date Assigned:	07/02/2014	Date of Injury:	09/08/2011
Decision Date:	05/01/2015	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/16/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery

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 64-year-old male, who sustained an industrial injury on 09/08/2011. The injured worker was diagnosed as having cerebral concussion with cephalgia, cervical spine sprain/strain, herniated cervical disc, left shoulder sprain/strain, status post subacromial decompression six years ago, right shoulder sprain/strain with glenoid labral tear and rotator cuff tear, status post right shoulder arthroscopy with subacromial decompression 06/14/2014, right and left rib cage contusion rule out fractures, lumbar spine strain/sprain, herniated lumbar disc, status post right knee video arthroscopic surgery in 2012 with degenerative joint disease, status post Hyalgan injections x 3, right ankle sprain/strain rule out internal derangement, history of diabetes and rule out anemia. On 06/14/2014, the injured worker underwent right shoulder surgery followed by post-op physical therapy. According to the most recent progress report dated 03/12/2015, the injured worker complains of pain in the right shoulder and bilateral wrists/hands. The injured worker received an injection of Toradol intramuscularly. Prescriptions included Ultram, Norco and Zanaflex. The injured worker remained temporarily totally disabled.

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, Labral Repair, and Rotator Cuff Repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter; Indications for Surgery Rotator Cuff Repair; ODG: SLAP Lesion Diagnosis; ODG: Surgery for SLAP Lesions.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guideline, Shoulder Chapter, 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 3/12/15 do not demonstrate 4 months of failure of activity modification. The physical exam from 3/12/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore, the determination is for non-certification for the requested procedure.

Internal Medicine Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Preoperative Testing.

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

Pre-Operative EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Preoperative Testing.

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

