

Case Number:	CM15-0001436		
Date Assigned:	01/12/2015	Date of Injury:	04/27/2013
Decision Date:	04/07/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/05/2015

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 04/27/2013. He has reported subsequent neck and bilateral shoulder pain and was diagnosed with cervical and bilateral shoulder sprain and strain, cervical spondylosis and tendinitis/impingement syndrome of the bilateral shoulders with full thickness rotator cuff tears. Treatment to date has included medication, injections, acupuncture, home exercises and physical therapy. In a progress note dated 11/24/2014, the injured worker complained of continued pain, stiffness and weakness to both shoulders, worse on the left and neck and upper back pain. The physician noted that the injured worker had undergone extensive conservative treatment of the left shoulder with no lasting relief. Requests for bilateral shoulder cortisone injections, bilateral shoulder arthroscopy with rotator cuff repair and post-operative physical therapy were submitted. On 12/29/2014, Utilization Review non-certified requests for right and left shoulder cortisone injections, noting that the request was vague. Utilization review modified requests for post-operative physical therapy from 18-24 visits to 2 x a week for 6 weeks for left shoulder postoperative, noting that approval of further visits should be contingent upon scheduling of right shoulder surgery, and modified a request for right and left shoulder arthroscopy with rotator cuff repair to left shoulder arthroscopy with rotator cuff repair, noting that the right arthroscopy should only be approved if the left arthroscopy was successful. ACOEM and ODG guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with Rotator Cuff Repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Surgery for rotator cuff repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, 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 11/24/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 11/24/14 does not demonstrate relief from anesthetic injection. Therefore the determination is for non-certification for the requested procedure.

Right Shoulder Cortizone Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: According to CA MTUS/ACOEM guidelines 2nd edition, Chapter 9, Shoulder complaints, page 204, Initial care, subacromial injection may be indicated after conservative therapy for two to three weeks. In this case the exam note from 11/24/14 does not indicate if recent conservative care has been attempted and failed. Therefore the guideline has not been satisfied and determination is for non-certification.

Left Shoulder Cortizone Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: According to CA MTUS/ACOEM guidelines 2nd edition, Chapter 9, Shoulder complaints, page 204, Initial care, subacromial injection may be indicated after conservative therapy for two to three weeks. In this case the exam note from 11/24/14 does not indicate if recent conservative care has been attempted and failed. Therefore the guideline has not been satisfied and determination is for non-certification.

Post-Operative Physical Therapy 18-24 Visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

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