

Case Number:	CM15-0003619		
Date Assigned:	01/26/2015	Date of Injury:	05/12/2011
Decision Date:	03/16/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/07/2015

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: New York, New Hampshire, Washington
 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 49 year old female, who sustained an industrial injury on May 12, 2011. She has reported bilateral shoulder pain. The diagnoses have included right rotator cuff impingement, AC joint arthrosis, biceps tendinitis, rotator cuff tear. Treatment to date has included cortisone injections, home exercises, and pain medications. Currently, the injured worker complains of bilateral shoulder pain. Previous cortisone injections are reported as providing minimal pain relief. She complains of right shoulder pain located in the lateral deltoid area aggravated by overhead or repetitive use and left shoulder pain. On examination the injured worker had right shoulder range of motion of 180/90/80 with tenderness at the AC joint and a possible impingement sign. There is no rotator cuff weakness and there is pain with abduction strength testing. The biceps are symmetrical and motor and sensory exams were normal. On December 22, 2014 Utilization Review non-certified a request for right shoulder acromioplasty, Mumford, possible labral repair, possible biceps; pre-operative laboratory to included CBC/CMP, Cold Therapy Unit/Immobilizer and post-operative physical therapy noting that there was no documentation of additional objective findings such as week or absent abduction and no documentation of the proposed duration of the cold therapy unit. Because the surgery was not certified the request for the associated pre-operative laboratory to included CBC/CMP, Cold Therapy Unit/Immobilizer and post-operative physical therapy was not certified. The California Medical Treatment Utilization Schedule and the Official Disability Guidelines were cited. On January 7, 2015, the injured worker submitted an application for IMR for review of right shoulder acromioplasty, Mumford, possible labral repair, possible biceps; pre-operative

laboratory to included CBC/CMP, Cold Therapy Unit/Immobilizer and post-operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Acromioplasty, Mumford, Possible Labral Repair, Possible Biceps Tenodesis, Possible Rotator Cuff Repair: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-220.

Decision rationale: 29 year old female with chronic right shoulder pain. Physical exam does not show significant loss of motion or weakness. MRI does not show complete rotator cuff tear. MTUS criteria for shoulder surgery not met at this time. There is no clear correlation between exam and imaging. No red flags for shoulder surgery are present.

Associated Surgical Services: Pre-Operative Laboratory: CBC/CMP: Upheld

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

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.

Associated Surgical Services: DME: Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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.

Associated Surgical Services: DME: Immobilizer: Upheld

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

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.

Twelve Sessions of Post-Operative Physical Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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.