

Case Number:	CM15-0101610		
Date Assigned:	06/04/2015	Date of Injury:	02/22/2015
Decision Date:	07/09/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/27/2015

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 52-year-old female with an industrial injury dated 02/22/2015. The mechanism of injury is documented as lifting a patient from a wheelchair when the patient fell backwards onto the wheelchair pulling the injured worker's right shoulder. Her diagnosis is sprain/strain right shoulder. Prior treatment included oral medications, physical therapy (no significant relief) and cortisone injection. MRI right shoulder demonstrates moderate tendinopathy without full thickness or high-grade tear. She presents on 03/26/2015 for orthopedic evaluation with complaints of right shoulder pain. Pain is over the anterior and posterior aspects of the shoulder. It worsens with reaching and overhead activities. She experiences pain at night. The treatment plan consisted of right shoulder arthroscopy, subacromial decompression, distal clavicle resection, bicep tendodesis, and rotator cuff repair, sessions post-operative physical therapy, associated surgical services: 7-day cold therapy unit rental (authorized), associated surgical services: simple sling purchase (authorized).

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, subacromial decompression, distal clavicle resection, bicep tendodesis, rotator cuff repair: 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 (ODG), shoulder chapter.

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) Shoulder section, surgery for rotator cuff repair.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 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 3/26/15 do not demonstrate 4 months of failure of activity modification. The MRI of the right shoulder does not demonstrate a clear surgical lesion. Therefore the determination is for not medically necessary for the requested procedure.

Postoperative physical therapy, (number of sessions, unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.