

Case Number:	CM15-0108267		
Date Assigned:	06/18/2015	Date of Injury:	08/22/2013
Decision Date:	07/16/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	06/04/2015

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 50 year old male who sustained an industrial injury on 8/22/13 after lifting pipes and climbing ladders he experienced bilateral shoulder pain that worsened overnight, the left shoulder worse than the right. He was medically evaluated and given medications and time off. He was then seen on 9/2013 and had x-rays, MRI of the left shoulder, was given medications, and had physical therapy. On 11/2013 he had left shoulder surgery without relief and had more physical therapy. He currently complains of bilateral shoulder pain worse on the left with upper arm pain. His pain level for the left shoulder is 9/10 and the right 5/10. On physical examination of the shoulder there was tenderness over the acromion and anterior aspect bilaterally with decreased range of motion. There was positive impingement sign bilaterally and positive cross arm on the right. His activities of daily living are limited in the areas of dressing (some difficulty), rising from a chair (some difficulty); some difficulty with sleep, travel. Diagnoses include left shoulder impingement syndrome and acromioclavicular joint disease, status post arthroscopic shoulder surgery-Left with amnioplasty and Mumford (1/2014); post-operative arthrofibrosis/ pain, left shoulder; right shoulder acromioclavicular joint degenerative joint disease. Treatments to date include physical therapy; medications; bilateral cortisone injections with short term relief of about one week; home exercise; ice; heat. Diagnostics include computed tomography of the left shoulder (9/5/14) showing a tear involving the anteroinferior glenoid labrum, tendinopathy, biceps tenodesis; MRI of the left shoulder (5/19/14) demonstrating post- surgical changes, moderate rotator cuff tendinosis, degeneration/ tear of the superior, anterior and posterior labrum, joint effusion; x-ray of the left shoulder

(8/12/14) was normal. On 1/27/15 the treating provider's plan of care includes a request for left shoulder arthroscopic labral repair, possible subacromial decompression and possible rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder A/S with anterior labral repair possible SAD 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 (ODG), Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 209-210. Decision based on Non-MTUS Citation (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 1/27/15 do not demonstrate 4 months of failure of activity modification. The physical exam from 1/27/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the request is not medically necessary.

Associated Surgical Service: EKG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Low Back, Preoperative testing.

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

Associated Surgical Service: CBC and 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 (ODG), Low Back Chapter; Preoperative lab testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Low Back, Preoperative testing.

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