

Case Number:	CM15-0019340		
Date Assigned:	02/09/2015	Date of Injury:	06/06/1997
Decision Date:	04/02/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/03/2015

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 was a 59 year old female, who sustained an industrial injury, June 6, 1997. The injury was sustained while performing usual and customary work activities. After cleaning up a septic spill, the injured worker felt pain in the neck, upper back and shoulder blades. According to progress note of October 7, 2014, the injured worker was not sleeping well, due to pain in the left and shoulders, left being worse than the right. The physical exam noted decreased range of motion, decreased abduction in the left shoulder, with no swelling, scar or deformity, no crepitus, no tenderness over the coracoacromial arch, positive impingement syndrome, no weakness of the rotator cuff strength and negative Jobe's test. The injured worker was diagnosed with cervical spine strain/sprain, right shoulder subacromial decompression and subacromial bursectomy, right shoulder manipulation, right carpal tunnel syndrome, lumbar strain/sprain, left shoulder impingement syndrome. The injured worker previously received the following treatments of Norco, Ibuprofen, Carisoprodol, Flexeril, laboratory studies, electrodiagnostic studies and right shoulder open rotator cuff repair on April 14, 2014. The documentation submitted for review did not include an MRI or report of the MRI of the left shoulder or other diagnostic studies or the left shoulder to confirm a diagnosis. On January 23, 2015, the primary treating physician requested authorization for open subacromial decompression and rotator cuff repair of the left shoulder and postoperative physical therapy. On January 30, 2015, the Utilization Review denied authorization for open subacromial decompression and rotator cuff repair of the left shoulder and postoperative physical therapy. The denial was based on the MTUS/ACOEM and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Open subacromial decompression and rotator cuff repair left shoulder: Upheld

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

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 10/27/14 do not demonstrate 4 months of failure of activity modification. In addition there is not a formal MRI report for review. The physical exam from 10/27/14 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.

Post op physical therapy for left shoulder x 12 sessions: Upheld

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

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.