

Case Number:	CM15-0136549		
Date Assigned:	07/24/2015	Date of Injury:	03/27/2014
Decision Date:	08/24/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	07/14/2015

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, Indiana, Oregon
 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 (IW) is a 46-year-old female who sustained an industrial injury 03/27/2014. Diagnoses/impressions include right shoulder rotator cuff tear with AC joint arthritis. Treatment to date has included medications and home exercise. Electrodiagnostic studies done 3/19/15 were positive for right carpal tunnel syndrome. According to the progress notes dated 4/22/15, the IW reported persistent right shoulder pain, aggravated by reaching and overhead activities. She reported having pain at night. On examination, the IW had 160 degrees of forward flexion of the right shoulder, 70 degrees of external rotation, 40 degrees of extension and 50 degrees of internal rotation. There was tenderness over the acromioclavicular (AC) joint and positive impingement signs. There was also diffuse tenderness over the posterior trapezius extending down into the parascapular region. MRI of the right shoulder on 1/13/15 showed a moderate-sized full thickness tear of the bursal half of the supraspinatus tendon without retraction and hypertrophic changes of the AC joint. A request was made for right shoulder arthroscopy possible SAD (subacromial decompression), possible DCR, possible labral repair, possible biceps tenodesis, possible RCR (rotator cuff repair), 12 post-operative physical therapy visits, Ultrasling with pillow purchase and cold therapy unit with pillow - rental x 14 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, possible SAD, 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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 exam note from 4/22/15 does not evidence that a steroid injection has been trialed and failed. Based on this, the request is not medically necessary.

12 post-operative physical therapy visits: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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

Ultrasling purchase: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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

Cold therapy unit 7 day rental: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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