

Case Number:	CM15-0180154		
Date Assigned:	09/22/2015	Date of Injury:	09/26/2014
Decision Date:	11/25/2015	UR Denial Date:	08/30/2015
Priority:	Standard	Application Received:	09/14/2015

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 is a 34 year old female who sustained an industrial injury on 09-26-14. A review of the medical records reveals the injured worker is undergoing treatment for left shoulder pain, lumbar and cervical spine sprain and strain, as well as bilateral knee sprain and strain. Medical records (08-21-15) reveal the injured worker complains of left shoulder pain, unrated. The physical exam (08-21-15) reveals tenderness to palpation in the cervical spine and left shoulder. Treatment has included chiropractic care and work restrictions. The MRI of the left shoulder (11-17-14) showed an intrasubstance tear in the infraspinatus tendon without retraction. The original utilization review (08-30-15) noncertified the request for arthroscopic decompression, distal clavicle resection, rotator cuff debridement and-or repair, preoperative medical clearance, 12 sessions of postoperative supervised rehabilitative therapy, continuous passive motion device - 45 day rental, Surgi-Stim Unit - 90 day rental, and shoulder immobilizer with abduction pillow.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Decompression, Distal Clavical Resection, Rotator Cuff Debridement and/or Repair: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.
Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - Indications for Surgery, Acromioplasty, Partial claviclectomy; Surgery for impingement syndrome.

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, pages 209 and 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 imaging does not demonstrate full thickness rotator cuff tear. The request is not medically necessary.

Pre Operative Medical Clearance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post Operative, Supervised Rehabilitative Therapy, 12 sessions: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Surgical Services: Continuous Passive Motion device, 45 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 cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Surgical Services: Surgi-Stim Unit, 90 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 cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Surgical Services: Shoulder Immobilizer with Abduction Pillow: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.