

Case Number:	CM15-0189805		
Date Assigned:	10/01/2015	Date of Injury:	11/17/2014
Decision Date:	12/18/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/25/2015

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:

This injured worker is a 50 year old female, who sustained an industrial injury on 11-17-2014. The injured worker was diagnosed as having lumbar spine-strain and right shoulder impingement. On medical records dated 09-01-2015 and 08-04-2015, the subjective complaints were noted as low back and right shoulder pain. No objective findings were noted. Treatments to date included medication. MRI of right shoulder pain on 05-01-2015 revealed complete versus near complete tear supraspinatus tendon with retraction. There is no muscle atrophy noted, osteoarthritis acromioclavicular joint and small amount of fluid with the subacromial-subdeltoid bursa. The injured worker was noted to be temporary total disability. Current medications were listed as Tramadol HCL, Pantoprazole Sodium DR and Diclofenac Sodium and compound cream. The Utilization Review (UR) was dated 09-02-2015. A request for outpatient acromioplasty and repair of right shoulder associated surgical service: medical clearance (doctor appointment), associated surgical service: cardiology clearance, postoperative physical therapy three (3) times a week for four weeks and associated surgical service: purchase of sling was submitted. The UR submitted for this medical review indicated that the request for outpatient acromioplasty and repair of right shoulder associated surgical service: medical clearance (doctor appointment), associated surgical service: cardiology clearance, postoperative physical therapy three (3) times a week for four weeks and associated surgical service: purchase of sling was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient acromioplasty and repair of right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Acromioplasty.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Acromioplasty surgery.

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. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 8/4/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 8/4/15 does not demonstrate evidence satisfying the above criteria. Therefore the request is not medically necessary.

Associated surgical service: Medical clearance (Dr. appointment): 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: Cardiology 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Postoperative physical therapy three (3) times a week for four (4) weeks: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: Purchase of sling: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.