MAXIMUS Federal Services

Case Number:	CM15-0196552		
Date Assigned:	10/12/2015	Date of Injury:	02/12/2008
Decision Date:	12/24/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/06/2015

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 53-year-old female, who sustained an industrial injury on 2-12-2008. She has reported injury to the neck and bilateral shoulders. The diagnoses have included cervical and lumbar strains with disc disease; status post left shoulder surgery; right shoulder impingement, symptomatic; and depression. Treatment to date has included medications, diagnostics, injections, and surgical intervention. Medications have included Norco and Zanaflex. A progress note from the treating physician, dated 09-02-2015, documented a follow-up visit with the injured worker. The injured worker reported that she has now decided that she wants to move forward with the surgery on the right shoulder; she is having too much pain; she requested a shot; she is working on a part-time job; the subjective remains worse on the right shoulder, also on the back, and to a degree of the left shoulder; and she reports difficulty sleeping and depression. Objective findings included the forward flexion on the right shoulder is 120 degrees and on the left shoulder is 160 degrees; there is tenderness on palpation on the right shoulder with grip on the right about 25 and on the left 45; and the provocative testing was positive. The MRI of the right shoulder, dated 05-14-2015, revealed moderate tendinosis of the supraspinatus and infraspinatus tendons and mild tendinosis of the subscapularis tendon in the right shoulder; and mild-to-moderate osteoarthritic change at the acromioclavicular joint, without evidence of mass effect on the rotator cuff or associated subacromial-subdeltoid bursitis. The treatment plan has included the request for outpatient right shoulder arthroscopy with decompression and possible rotator cuff repair; associated surgical services: assistant surgeon, exercise kit, and cold therapy unit; Keflex cap 500mg #15; and post-op sling. The original utilization review, dated 09-

30-2015, non-certified the request for outpatient right shoulder arthroscopy with decompression and possible rotator cuff repair; associated surgical services: assistant surgeon, exercise kit, and cold therapy unit; Keflex cap 500mg #15; and post-op sling.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient right shoulder arthroscopy with decompression & possible rotator cuff repair: Upheld

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

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, 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 9/2/15 do not demonstrate 4 months of failure of activity modification. The physical exam from 9/2/15 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: assistant surgeon: 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: Exercise kit: 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.

Keflex cap 500mg #15: 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: Cold therapy unit: 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.

Post-op 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.