

Case Number:	CM15-0199919		
Date Assigned:	10/15/2015	Date of Injury:	03/10/2010
Decision Date:	11/25/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/12/2015

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: Montana, Oregon, Idaho

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 42-year-old female, with a reported date of injury of 03-10-2010. The diagnoses include left shoulder pain, left shoulder sprain and strain, left shoulder impingement, left acromioclavicular joint arthralgia and arthrosis, left partial thickness supraspinatus tear bursal surface, and disorder of bursa of the left shoulder region. Treatments and evaluation to date have included Tramadol, Cyclobenzaprine, and Diclofenac. The diagnostic studies to date have included an MRI of the left shoulder on 07-22-2015 which showed micro-metallic artifact around the acromion suggested prior surgery, and minor tendinosis in the supraspinatus tendon. The progress report dated 09-21-2015 indicates that the injured worker had pain in the left shoulder associated with numbness and tingling, catching, popping, clicking, and grinding. The injured worker worked modified duty. The objective findings were not recorded. The treating physician requested left shoulder arthroscopy, subacromial decompression with partial acromioplasty, excision distal clavicle and possible rotator cuff repair, post-operative physical therapy for the left shoulder two times a week for six weeks, and purchase of a post-operative left shoulder brace. On 10-01-2015, Utilization Review (UR) non-certified the request for left shoulder arthroscopy, subacromial decompression with partial acromioplasty, excision distal clavicle and possible rotator cuff repair, post-operative physical therapy for the left shoulder two times a week for six weeks, and purchase of a post-operative left shoulder brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Possible Rotator Cuff Repair, Left Shoulder Arthroscopy, SAD w/partial Acromioplasty, Excision Distal Clavicle: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indication for surgery, Rotator Cuff Repair.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. 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 submitted notes from do not demonstrate 4 months of failure of activity modification or physical therapy prior to surgery. The physical exam from does not demonstrate a painful arc of motion and relief from anesthetic injection but not night pain. In addition, the MRI from 7/22/15 does not demonstrate a lesion which has been shown to benefit from surgical repair official MRI report not submitted in documents available for review Therefore the request does not meet the criteria set forth in the guidelines and the request is not medically necessary.

Post-op Left Shoulder Brace for purchase: 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-op Physical Therapy 2 times a week for 6 weeks left shoulder: 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.