

Case Number:	CM15-0041758		
Date Assigned:	03/12/2015	Date of Injury:	06/18/2014
Decision Date:	05/12/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/05/2015

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, Sports Medicine

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 70-year-old male who reported an injury on 06/18/2014. The mechanism of injury was a fall. His diagnoses were noted to include right shoulder rotator cuff tear. There were no pertinent diagnostic studies provide. His surgical history was noted to include right total knee replacement. During the assessment on 02/03/2015, the injured worker was seen for his injury to the right knee. The injured worker described the pain as dull and rated the pain a 3/10. The physical examination of the right shoulder revealed range of motion of flexion of 90 degrees, abduction of 100 degrees, and external rotation of 70 degrees. The strength testing of the supraspinatus revealed 4/5 and external rotation 4+/5. There was periacromial tenderness noted. There was decreased motor strength in the right shoulder. It was noted that the injured worker underwent electromyography and nerve conduction studies and the suprascapular nerve was noted to be intact. The treatment plan was to proceed with a right shoulder arthroscopy with rotator cuff repair. The rationale for the request was due to the injured worker's severe loss of right shoulder motion and weakness. The Request for Authorization form was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery right shoulder arthroscopy with rotator cuff repair quantity: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) California Guidelines Plus. Web-based version.

MAXIMUS guideline: Decision based on MTUS ACOEM.

Decision rationale: The request for surgery right shoulder arthroscopy with rotator cuff repair quantity 1 is not medically necessary. The California MTUS/ACOEM Guidelines state for partial thickness rotator cuff tears and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The clinical documentation did not indicate that the injured worker had failed 3 months of conservative therapy. Additionally, there was no positive evidence of deficit in the rotator cuff provided on imaging clinical studies, such as MRI. As such, this request is not medically necessary.

Assistant surgeon quantity: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation cms.gov 250.9- Coding Assistant at Surgery Services Rendered in a Method II CAH (Rev.1620; Issued: 10-24-08; Effective 01-01-08; Implementation 04-06-09.

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 physical therapy quantity: 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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: right shoulder arm sling quantity: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation (ODG-TWC) ODG Treatment; Integrated Treatment/Disability Duration Guidelines.

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.