

Case Number:	CM15-0077189		
Date Assigned:	05/07/2015	Date of Injury:	08/13/2011
Decision Date:	08/04/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	04/22/2015

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 then 49 year old female, sustained an industrial injury on 08/13/2011. According to a progress report dated 02/11/2015, the injured worker was having continued pain and discomfort in her right shoulder. She initially had surgery on 11/11/2011 consisting of an acromioplasty and distal clavicle resection. She did not do well with that surgical procedure according to the provider. An MRI on May 18, 2012 revealed evidence of a right shoulder rotator cuff tear and she underwent a surgical procedure on 02/19/2013 consisting of an arthroscopic rotator cuff repair and revision acromioplasty, distal clavicle resection. She continued to have persistent pain following re-injury and underwent an MRI that revealed evidence of a recurrent full-thickness supraspinatus tendon tear per provider report. Physical examination demonstrated well-healed arthroscopic portal sites of the right shoulder. Forward elevation was to 120 degrees, external rotation was to 20 degrees and internal rotation was to L5. Abduction strength was 4-/5. She had positive lift-off, positive impingement signs 1, 2, and 3, negative Speed and Yergason tests. Diagnoses included right shoulder failed rotator cuff repair, left shoulder impingement and left shoulder rotator cuff tendon tearing. The provider noted that the request for surgery had been non-authorized. The provider recommended a right shoulder MRI arthrogram to be performed to document the size of the rotator cuff tear. Formal MRI report of the right shoulder is not available for review. The provider noted that authorization had also been requested for a left shoulder arthroscopic acromioplasty and rotator cuff repair. A prescription for Norco was given. Currently under review is the request for right and left shoulder surgery, associated surgical services and pain medications. Radiographic imaging reports were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopic Debridement and Revision Rotator Cuff Repair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2014, Shoulder, Surgery for rotator cuff repair, Surgery for impingement syndrome.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation 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 MRI of the right shoulder is not available for review. There is insufficient evidence to support any surgical intervention until the MRI report is available. Therefore the determination is not medically necessary for the requested procedure.

Pre-Operative Laboratory Works: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Norco 10/325mg #60: 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.

Percocet 10/325mg #60: 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-Operative Physical Therapy Visits x 12: 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: 14 Days Rental of Vascutherm Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2014, Shoulder, Cold Compression Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Cold compression therapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, Cold compression therapy, it is not recommended in the shoulder as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. As the guidelines do not recommend the requested DME, the determination 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Left Shoulder Arthroscopic Acromioplasty and Rotator Cuff Repair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2014, Shoulder, Surgery for impingement syndrome.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, 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 MRI of the left shoulder is not available for review. There is insufficient evidence to support any surgical intervention until the MRI report is available. Therefore the determination is not medically necessary for the requested procedure.