

Case Number:	CM15-0083584		
Date Assigned:	05/05/2015	Date of Injury:	07/01/2012
Decision Date:	08/04/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/01/2015

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 35-year-old female, with a reported date of injury of 07/01/2012. The diagnoses include right shoulder impingement syndrome and status postindustrial right shoulder sprain/strain injury. Treatments to date have included an MRI of the right shoulder on 02/10/2014 which denied a rotator cuff tear, but showed tendinosis and peritendinitis of the supraspinatus tendon; two cortisone injections; and physical therapy. The comprehensive orthopedic consultation report dated 01/19/2015 indicates that the injured worker had right shoulder symptoms, and she failed all attempts of aggressive conservative measures. She rated her pain 8-9 out of 10. The physical examination showed decreased right shoulder range of motion; severe right supraspinatus tenderness; moderate right greater tuberosity tenderness; mild right biceps tendon tenderness; moderate acromioclavicular (AC) joint tenderness; positive right subacromial crepitus; positive reflexes; positive right AC joint compression test; and positive right shoulder impingement. The treating physician requested right shoulder arthroscopic evaluation, subacromial decompression, distal clavicle resection, possible rotator cuff debridement and/or repair; pre-operative medical clearance; post-operative rehabilitative therapy; home continuous passive motion (CPM) device; Surgi-stim unit; and Coolcare cold therapy unit. On 04/21/2015, Utilization Review (UR) denied the request because there was no documentation of when the cortisone injections were given and if they had a transient effect of pain relief; the MRI study did not confirm acromioclavicular (AC) joint arthrosis; the MRI study indicated that the rotator cuff was not torn or frayed; and since the surgery is not medically necessary, all the subsequent and related requests are not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopic Evaluation, Arthroscopic Subacromial Decompression, Distal Clavicle resection, Possible rotator cuff debridement and/or repair as indicated: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Diagnostic Arthroscopic section, Surgery Chapter, Indication for Surgery - Rotator Cuff repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 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, 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 1/19/15 do not demonstrate 4 months of failure of activity modification. The physical exam from 1/19/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the request is not medically necessary.

Associated Surgical Services: Post-Operative Medical Clearance with MD or an Associate: 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.

Associated Surgical Services: Post-Operative Rehabilitate Therapy, 12 sessions, 3 x 4: 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 Services: Home Continuous Passive Motion (CPM) Device, Initial period 45 days: 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 ODG, Knee and leg section, CPM.

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

Associated Surgical Services: Surgi-Stim Unit, Initial 90 days: 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 Services: Coolcare 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 base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter, Continuous flow cryotherapy.

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