

Case Number:	CM15-0089612		
Date Assigned:	05/28/2015	Date of Injury:	06/15/2011
Decision Date:	08/18/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	05/11/2015

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 60 year old male, who sustained an industrial injury on 06/15/2011. He has reported injury to the bilateral shoulders and bilateral knees. The diagnoses have included status post left shoulder arthroscopy, on 08/20/2014; status post right shoulder arthroscopy, on 09/07/2013; right knee medial meniscal tear with chondromalacia of the patella; and status post left knee arthroscopy, on 06/30/2012. Treatment to date has included medications, diagnostics, physical therapy, and surgical interventions. Medications have included Norco. A progress note from the treating physician, dated 03/12/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of pain in the left shoulder; pain in the left knee; the pain and symptoms are about the same; and he has difficulty with overhead activities. Objective findings included tenderness to palpation at the greater tuberosity of the left humerus at deltoid and parascapular musculature; and MRI of the left shoulder with arthrogram, dated 02/02/2015, shows: full thickness tear of supraspinatus tendon with superior migration of humeral head; partial tear of subscapularis and infraspinatus tendons; osteoarthropathy of acromioclavicular joint; lateral down-sloping of acromion process, and tear of anterior and superior glenoid labrum. The treatment plan has included the request for left shoulder arthroscopy versus open rotator cuff repair, possible fascia graft; internal medicine evaluation (surgical clearance); electrocardiogram (EKG); Norco 10/325mg #120; hot and cold contrast unit (purchase); and pro-sling with abduction pillow (purchase).

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy versus open rotator cuff repair, possible fascia graft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (online version), Graft, rotator cuff.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff tear.

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 3/12/15 do not demonstrate 4 months of failure of activity modification. The physical exam from 3/12/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is not medically necessary for the requested procedure.

Internal medicine evaluation (surgical 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.

Associated surgical service: EKG: 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 #120: 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: hot and cold contrast unit (purchase): 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.

Associated surgical service: pro-sling with abduction pillow (purchase): 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 (ODG) Shoulder Abduction pillow.

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