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| Case Number: | CM14-0143698 | | |
| Date Assigned: | 09/12/2014 | Date of Injury: | 09/11/2013 |
| Decision Date: | 10/10/2014 | UR Denial Date: | 08/14/2014 |
| Priority: | Standard | Application Received: | 09/04/2014 |

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Pennsylvania. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 46-year-old gentleman who sustained an injury to the left upper extremity on 09/11/13. The clinical records provided for review included an assessment on 07/11/14 noting complaints of left shoulder pain and left greater than right hand pain. Objectively, on examination there was restricted left shoulder range of motion, markedly positive impingement signs, positive Neer and Hawkin's testing. Examination of the hand revealed a positive Tinel's sign indicative of carpal tunnel syndrome. The report of the electrodiagnostic studies dated 05/27/14 showed mild-to-moderate median mononeuropathy at the wrist, left greater than right, indicative of carpal tunnel syndrome. The assessment documented that the claimant had failed conservative care including physical therapy, medication management and activity restrictions. There is no documentation of a corticosteroid injection to the shoulder. Imaging report of a shoulder MRI dated 06/04/14 identified a partial undersurface tear of the supraspinatus but no full thickness tearing or retraction. There was hypertrophy change to the acromioclavicular joint and a down sloping acromion. This request is for left shoulder surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic subacromial decompression and rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery, Rotator Cuff Repair

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: Based on California ACOEM Guidelines, the request for left shoulder left shoulder arthroscopic subacromial decompression and rotator cuff repair cannot be recommended as medically necessary. ACOEM Guidelines recommend that conservative care, including cortisone injections, can be carried out for at least three months before considering surgery. The medical records do not document that the claimant has received three months of conservative care including injection therapy to satisfy the ACOEM Guideline criteria for surgery of a partial thickness rotator cuff tear. Without documentation of the above, acute need of surgical request would not be indicated.

12 post operative physical therapy sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The proposed left shoulder surgery is not recommended as medically necessary. Therefore, the request for twelve sessions of postoperative therapy is also not medically necessary

Tramadol 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids-Tramadol (Ultram) Page(s): 91-94, 75..

Decision rationale: The proposed surgery is not recommended as medically necessary. Therefore, the request for postoperative use of Tramadol is also not medically necessary.