MAXIMUS Federal Services

Case Number:	CM14-0125312		
Date Assigned:	08/11/2014	Date of Injury:	08/25/2010
Decision Date:	06/29/2015	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/07/2014

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. 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: Minnesota, Florida
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 46-year-old male who sustained an industrial injury on 08/25/10. Initial complaints included neck and right shoulder pain. Initial diagnoses are not available. Treatments to date include medications, acupuncture, chiropractic therapy, right shoulder elbow and neck injections, right shoulder surgery, physical therapy, and a TENS unit. Diagnostic studies include x-rays and MRIs. Current complaints include bilateral shoulder pain. Current diagnose include left shoulder impingement and partial thickness rotator cuff tear, cervical spondylosis, cervical strain with radiculitis, cervical stenosis, and painful snapping scar tissue band right shoulder. In a progress note dated 06/20/14, the treating provider reports the plan of care as bilateral shoulder surgeries, and medications including Omeprazole and Norco. The requested treatment is right shoulder surgery and associated services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with extensive Debridement, Subacromial Decompression, Coracoacromial Ligament Release, Labral Repair, Rotator Cuff Repair and Injection of Marcaine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211.

Decision rationale: The primary treating physician's progress PR-2 request for surgery authorization report dated June 20, 2014 is reviewed. The injured worker is a 43-year-old right-hand-dominant male with a date of injury of August 25, 2010. He stated that he was pushing a roll of insulation up the stairs when he injured his right shoulder. Subsequently the pain also involving the neck and left shoulder. The neck pain radiated down the right upper extremity more so than the left and was associated with paresthesias and numbness in both hands. He underwent arthroscopy of the right shoulder with acromioplasty and extensive debridement of a superior labral tear and injection with Marcaine on 6/19/2013. Unfortunately, the surgery did not relieve his symptoms. He stated that an MRI scan of the right shoulder was negative. MRI of the cervical spine revealed C5-6 disc and osteophyte with mild flattening of the anterior spinal cord and borderline central canal spinal stenosis. At C6-7 there was mild left paracentral disc osteophyte protrusion. Examination of the left shoulder revealed impingement syndrome with MRI evidence of a partial-thickness distal infraspinatus rotator cuff tear and focal posterior labral tear with subacromial snapping. Examination of the right shoulder revealed a painful snapping scar tissue band. Flexion was 105 degrees and abduction 110 with pain. External rotation was 40 and internal rotation 15. X-rays of the right shoulder revealed a type III acromion. There was adequate acromioclavicular joint space noted. The MRI report pertaining to the right shoulder is not submitted. California MTUS guidelines indicate surgical considerations for activity limitation for more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. In this case, the MRI report is not submitted and therefore there is no imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. A prior subacromial decompression did not result in pain relief. Surgical considerations depend on the working or imaging confirmed diagnosis of the presenting shoulder complaint. In the absence of such imaging diagnosis, the request is not medically necessary.

Assistant Surgeon: 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: Shoulder Immobilizer and Sling: 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 (12-sessions): 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.