

Case Number:	CM14-0203255		
Date Assigned:	12/15/2014	Date of Injury:	02/15/2014
Decision Date:	02/25/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	12/04/2014

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. 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:

39-year-old female claimant with an industrial injury dated 02/15/14. MRI dated 03/29/14 reveals mild arthrosis acromioclavicular joint supraspinatus tendinosis without evidence of a full-thickness tear, with tendinosis involving the distal subscapularis tendon. Conservative treatments include a cortisone injection dated 06/30/14 without any benefit. Exam note 07/30/14 states the patient returns with cervical spine pain. The patient explains having difficulties with daily living activities. The patient rates the pain a 7/10 and also reports left shoulder pain in which she rates a 6-7/10. The patient explains that the symptoms are present 51-75% of the time in which include a dull aching, numbness, burning and tingling. Exam note 09/04/14 states the patient returns with pain. Upon physical exam there was evidence of tenderness over the anterior, lateral, and posterior aspects of the left shoulder as well as the left trapezius and scapular areas. There was no evidence of gross deformity, swelling, or scars. Range of motion was noted as an extension of 30' bilaterally, abduction 170' for the right shoulder and 140' for the left, 170' flexion for the right and 150' for the left, 60' of internal rotation bilaterally, and 80' external rotation bilaterally. It is noted that the left shoulder is positive for impingement syndrome. Diagnosis is noted as impingement syndrome of the left shoulder. Treatment includes an arthroscopic decompression, Mumford procedure, and a possible open rotator cuff repair for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic decompression, possible Mumford procedure, possible open rotator cuff repair of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

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 submitted notes from 9/4/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 9/4/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the request is not medically necessary.

Associated Surgical Service: Pre-op medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The American Academy of Orthopedic Surgeons, Orthopedic Knowledge Update, OKU 9, Jeffrey S. Fischgrund, MD: editor, Chapter 9 Perioperative Medical Management, page 105-113

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: Post-op physical therapy two times a week for four weeks for the left shoulder: Upheld

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

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.

