

Case Number:	CM14-0213706		
Date Assigned:	12/31/2014	Date of Injury:	10/30/2007
Decision Date:	03/03/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/22/2014

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:

53 year old female claimant with an industrial injury dated 10/30/07. Exam note 10/13/14 states the patient returns with right wrist and left shoulder pain. The patient complains of stiffness, tenderness, weakness and swelling. Upon physical exam the patient demonstrated a range of motion for the right shoulder with 110° flexion, 40° extension, 100° abduction, and 40° adduction. Exam impingement was noted as positive bilaterally. Current medications include Relafen, Lyrica, and Colace. Conservative treatments also include acupuncture and a home exercise program. Treatment includes a right shoulder arthroscopy, and physical therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic right shoulder evaluation, arthroscopic subacromial decompression, distal clavicle resection and rotator cuff repair.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 214. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

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 section, 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 10/13/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 10/13/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is for non-certification for the requested procedure.

Associated surgical service: pre-operative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: supervised post-operative rehabilitative therapy 3x4: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: home continuous passive motion (CPM) device for an initial period of 45 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: surgi-stim unit for an initial period of 90 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: coolcare cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.