

Case Number:	CM15-0013176		
Date Assigned:	02/02/2015	Date of Injury:	08/31/2001
Decision Date:	03/31/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/22/2015

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 65 year old female, who sustained a work related injury on 8/31/01 and 3/23/10. The diagnoses have included disc herniation of C6-7 cervical spine, rotator cuff tears both shoulders and herniated disc of L5-S1 lumbar spine. Treatments to date have included MRI right shoulder, x-rays, physical therapy, oral medications and injections into shoulder. In the initial orthopedic evaluation report dated 12/3/14, the injured worker complains of neck pain with some radiation to shoulders. She complains of numbness, tingling and weakness of both hands. She complains of low back pain. There is tenderness to palpation of neck muscles. She has limited range of motion in neck and bilateral shoulders. On 12/23/13, Utilization Review non-certified requests for chest x-ray, post-op pain pump, and post-op 1 month rental of IF unit. ODG was cited. On 12/23/13, Utilization Review modified request for post-op cold therapy unit for 7 day rental. ODG was cited. On 12/23/13, Utilization Review certified requests for right shoulder rotator cuff repair with assistant surgeon, post-op physical therapy x 12 visits, pre-op medical clearance EKG and labs-CBC, CMP, PT/PTT and UA; and post-op shoulder sling. The California MTUS, Postsurgical Treatment Guidelines, and ODG were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder rotator cuff repair with assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Official Disability Guidelines, Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 12/3/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 12/3/14 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.

Pre-op medical clearance: EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [Http://www.guideline.gov/content.aspx?id=48404](http://www.guideline.gov/content.aspx?id=48404) Perioperative protocol. Health care protocol. Official Disability Guidelines, Low Back

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

Pre op medical clearance: Chest x -ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [Http://www.guideline.gov/content.aspx?id=48404](http://www.guideline.gov/content.aspx?id=48404) Perioperative protocol. Health care protocol. Official Disability Guidelines, Low Back

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

Pre op medical clearance Labs: CBC, CMP, PT/PTT, UA: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation

[Http://www.guideline.gov/content.aspx?id=48404](http://www.guideline.gov/content.aspx?id=48404) Perioperative protocol. Health care protocol. Official Disability Guidelines, Low Back

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

Post op 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, Shoulder

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Continuous flow cryotherapy

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

Post op pain pump: 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, Shoulder Chapter, Postoperative pain pumps

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

Post op 1 month rental of IF Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Interferential Current Stimulation Page(s): 118.

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