

Case Number:	CM15-0018189		
Date Assigned:	02/06/2015	Date of Injury:	01/14/2013
Decision Date:	03/25/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/30/2015

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: Illinois, California, Texas
 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 50 year-old male who sustained an industrial related injury on 1/14/13. Injury occurred when he was lifting heavy pieces of merchandise. He underwent an umbilical hernia repair in February 2013. Past surgical history was positive for a remote right shoulder surgery. The 7/16/14 right shoulder MR arthrogram documented posterior change involving the anterior glenoid consistent with prior labral repair, a re-tear involving the anterior superior glenoid labrum, and diffuse degenerative changes involving the entire anterior labrum. The 10/31/14 treating physician report cited complaints of right shoulder and low back pain with headaches and sexual dysfunction. Right shoulder exam documented non-specific decreased range of motion and weakness in internal rotation, external rotation, and abduction. There was decreased lumbar range of motion. The diagnosis included right shoulder labral tear with impingement, and right sided lumbar pain with radiculopathy. The treatment plan indicated the patient was awaiting authorization for right shoulder surgery and recommended refill of his Tramadol and Ambien. The 12/9/14 treating physician report cited right shoulder, low back pain, and right left pain with headaches and stress. Physical exam documented decreased right shoulder range of motion, weakness in abduction and external rotation, decreased lumbar range of motion, and equivocal straight leg raise. The 12/18/14 pain management report cited complaints of low back pain radiating to the right lower extremity. Physical findings were limited to a lumbar spine exam. The diagnosis was low back pain with radiating right lower extremity symptoms, right sacroiliac joint arthropathy, and rule-out lumbar spondylosis. Medications included Norco, Tizanidine, and analgesic cream. Authorization for right shoulder

surgery was requested on 12/22/14. On 12/30/14 the request was non-certified. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted there was a lack of documented conservative care to include physical therapy notes and physical examination findings to support the need for surgery. The request submitted for review did not specify the type of surgery being requested. Therefore the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

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

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. Guideline criteria have not been met. This patient presents with right shoulder pain with no specific documentation of functional limitations. Clinical exam findings documented decreased range of motion and abduction and external rotation weakness, both not quantified. There is imaging evidence of post-surgical labral changes with re-tear and degeneration, not specifically correlated to the clinical exam. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. The requested surgical procedure has not been specified. Therefore, this request is not medically necessary at this time.