

Case Number:	CM15-0115465		
Date Assigned:	06/24/2015	Date of Injury:	03/12/2009
Decision Date:	09/17/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	06/16/2015

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, Oregon, Washington
 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 47 year old female who sustained an industrial/work injury on 3/12/09. She reported an initial complaint of right shoulder, neck, elbow, and wrist pain. The injured worker was diagnosed with right shoulder impingement syndrome, right shoulder rotator cuff tendinitis, and right shoulder adhesive capsulitis, cervical radiculopathy. Treatment to date includes medication, surgery (right shoulder arthroscopy on 11/11/14 with rotator cuff repair and subacromial decompression), physical therapy, chiropractic manipulation therapy, and home exercise program. MRI results was reported on 2/9/15 that demonstrated repair with a small transmural tear in the distal anterior supraspinatus tendon, long head biceps tendinosis with medial subluxation long head biceps tendon and superior bicipital groove, degeneration of the anterior superior labrum. Currently, the injured worker complained of right shoulder pain. Per the primary physician's report (PR-2) on 6/1/15, exam noted right shoulder pain at the anterolateral shoulder that increases with pushing, pulling, and overhead reach, night pain, and a sense of weakness. There was a positive impingement sign and abduction sign, slight weakness with external rotation, tenderness to the acromioclavicular (AC) joint, generalized tenderness involving the posterior shoulder musculature. The requested treatments include Outpatient right shoulder arthroscopy with subacromial decompression with mini-open rotator cuff repair, associated surgical service: using an assistant surgeon, Norco 10/325mg, Keflex 500mg, and outpatient post-op physical therapy (PT) to right shoulder three (3) times a week for four (4) weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient right shoulder arthroscopy with subacromial decompression with mini-open rotator cuff repair: 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) Indications for Surgery, Rotator cuff repair.

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

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 6/1/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 6/1/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the request is not medically necessary.

Associated surgical service: Assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Norco 10/325mg #40: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Keflex 500mg #8: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Outpatient post-op physical therapy (PT) to right shoulder three (3) times a week for four (4) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.