

Case Number:	CM15-0119505		
Date Assigned:	07/23/2015	Date of Injury:	12/22/2014
Decision Date:	08/24/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/22/2015

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, Indiana, Oregon
 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 52 year old female, who sustained an industrial injury on 12/22/14. She reported slipping and falling down 10 stairs, injuring left middle finger and ring finger, left wrist, right wrist and forearm, right shoulder, right chest-ribcage, right hip and left ankle. The injured worker was diagnosed as having right shoulder rotator cuff tear, status post right arm-forearm contusion with medial epicondylitis, status post left right finger PIP joint dislocation with strain of hand, status post left ankle sprain, status post contusion of right hip, ribs, chest (asymptomatic) and a psychiatric diagnoses. Treatment to date has included physical therapy, oral medications and activity restrictions. (MRI) magnetic resonance arthrogram of right shoulder performed on 5/4/15 revealed severe rotator cuff tendinosis with at least high grade partial thickness tear of the anterior supraspinatus footprint, moderate to severe acromial joint arthrosis and moderate subacromial-sub deltoid bursitis. Currently 5/13/15, the injured worker reported she is seeing a hand specialist, doing therapy for left ankle and possibly hand therapy, subjective complaints were not included on the progress note; on 4/24/15 she noted constant discomfort pain to left hand with tingling, numbness and weakness, right arm discomfort pain, left ankle discomfort pain and significant discomfort pain to the shoulder. She is currently not working. Physical exam performed on 6/16/15 revealed markedly positive Neer test with supraspinatus weakness on the right side without hypersensitivity to light touch in either upper extremity. A request for authorization was submitted on 5/13/15 and again on 5/28/15 for right shoulder exam under anesthesia with arthroscopic subacromial decompression, rotator cuff repair and-or debridement with treatment of other pathologies as indicated, per-op medical clearance, post-operative physical therapy, cold therapy unit purchase, cold therapy pad

purchase, cold therapy sterile wrap purchase, smart sling purchase and abduction pillow purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic subacromial decompression, rotator cuff repair and/or debridement, with treatment of other pathologies under anesthesia: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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 there is no evidence of full thickness rotator cuff tear. The request is not medically necessary.

Associated surgical service: Smart sling: Upheld

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

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: Abduction pillow: Upheld

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

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.

Post-op analgesic medication: 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 (ODG) shoulder.

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: Upheld

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

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.

Post-op physical therapy x 12: Upheld

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

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: Cold therapy unit: Upheld

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

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: Cold therapy unit pad: Upheld

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

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: Cold therapy sterile wrap: Upheld

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

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.