

Case Number:	CM15-0120627		
Date Assigned:	07/01/2015	Date of Injury:	12/08/2014
Decision Date:	09/22/2015	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
 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 43-year-old male who sustained a work related injury December 8, 2014. While holding up his arm to prevent a heavy box of totes from falling, he developed severe pain in the right shoulder as the boxes came down onto his right shoulder. Past history included hypertension. According to a physician's progress report, dated May 6, 2015, the injured worker presented with complaints of right shoulder pain, rated 10/10, with weakness and continues to worsen. He also reports continued pain in his neck primarily along the right side and along the upper shoulders. Examination of the cervical spine revealed paraspinal muscle tenderness on the right side in right trapezius and normal range of motion. Examination of the right shoulder revealed global tenderness over the suprascapular musculature and over the AC (acromioclavicular) joint. Range of motion documented as; right shoulder flexion 90 degrees, internal/external rotation 60 degrees and abduction 90 degrees. Drop-arm, Hawkins, Neer and cross-arm tests are positive. The physician further documents the injured worker has failed at non-surgical care through injections and physical therapy. Assessments are right shoulder rotator cuff tear; right shoulder tendinosis; impingement syndrome; AC joint arthritis; cervical strain. At issue, is request for authorization for right shoulder arthroscopy with rotator cuff repair with implants, subacromial decompression with distal claviclectomy, assistant surgeon, pre-operative medical clearance, post-operative Polar Care unit; post-operative right shoulder UltraSling, and post-operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with Rotator Cuff Repair with Implants, Subacromial Decompression with Distal Claviclectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG Shoulder, Partial Claviclectomy, Indications for Surgery.

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, 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 5/6/15 do not demonstrate 4 months of failure of activity modification. Therefore, the determination is for non-certification for the requested procedure.

Assistant Surgeon: 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.

Pre-Operative 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-Operative Polar Care 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.

Post-Operative Right Shoulder UltraSling: 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-Operative Physical Therapy for the Right Shoulder (12-sessions, 2 times a week for 6 weeks): 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.