

Case Number:	CM15-0120711		
Date Assigned:	07/01/2015	Date of Injury:	11/20/2014
Decision Date:	09/21/2015	UR Denial Date:	06/10/2015
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 66-year-old male, who sustained an industrial. The mechanism of injury is unclear. The injured worker was diagnosed as having right shoulder sprain, tendon rupture, and right lateral epicondylitis. Treatment to date has included medications, work restrictions, magnetic resonance imaging of the right shoulder (4/14/2015), physical therapy, and depomedrol/Marcaine injection. The request is for Norco; outpatient right shoulder arthroscopy with subacromial decompression, extensive debridement, rotator cuff repair and biceps tenotomy; assistant surgeon; outpatient physical therapy (PT) to the right shoulder; durable medical equipment (DME) purchase of post-operative sling. On 4/14/2015, a magnetic resonance imaging of the right shoulder revealed rupture of the supraspinatus and infraspinatus tendons which are retracted to just lateral to the glenohumeral joint, and humeral joint is high riding contacting the undersurface of the acromion, and atrophy of the infraspinatus muscle is demonstrated, subscapularis tendinopathy, small glenohumeral joint effusion, and moderate acromioclavicular joint arthrosis. On 6/1/2015, he is seen for right shoulder pain. Physical examination revealed full range of motion both actively and passively, positive impingement sign. The shoulder is noted to be stable. The treatment plan included: right shoulder surgery. On 6/30/2015, he is seen for right shoulder pain. He is reported to be taking Celebrex. He had a trial of doing regular work and was not able to work more than 4 hours per day for 2 days, then afterward is reported to have an inability to grasp and hold a coffee cup with his right upper extremity. Physical findings revealed a blood pressure of 140/78, tenderness along the collarbone, shoulder and deltoid area of the right upper extremity. Testing revealed a negative

Yergason's, positive Gerber liftoff sign, and a positive Cross arm test. He is also noted to have a positive sign of impingement, Hawkins maneuver, and empty can sign. The treatment plan included: continuing the Celebrex, modified work, and follow up.

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, extensive debridement, rotator cuff repair and biceps tenotomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints ,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty surgery.

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. 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 6/30/15. 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 6/30/15 does not demonstrate evidence satisfying the above criteria. Therefore the request is not medically necessary.

Post op physical therapy to the right shoulder 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.

Purchase of a post op 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.

Norco 5/325mg #75: 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.

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.