

Case Number:	CM15-0120999		
Date Assigned:	07/01/2015	Date of Injury:	09/02/2008
Decision Date:	08/06/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/23/2015

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 50 year old male who sustained an industrial injury on 9/2/08. He had complaints of left shoulder and arm pain. Treatments include medication; ultrasound guided left glenohumeral joint injection, injection to left shoulder with Kenalog and Lidocaine, physical therapy and arthroscopic surgery. Progress note dated 4/21/15 reports continued complaints of left shoulder pain extending into the trapezius and upper spine and bicep. The pain is constant, sharp, throbbing, aching and moderately severe. The pain is aggravated by lifting, pushing, pulling, attempting to lift arm overhead and grasping. Pain medications offer minimal improvement and the injections have not helped significantly and have been discontinued. Diagnosis is status post multiple surgeries of the left shoulder with residual rupture of the biceps tendon long head. Work status is permanent and stationary. Plan of care includes: continue medications, authorization for examination under anesthesia, manipulation and arthroscopy to improve range of motion and function, post op 24 physical therapy visits possibly more.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic rotator cuff repair per 05/26/15 order: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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 4/21/15 do not demonstrate 4 months of failure of activity modification. The physical exam from 4/21/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is not medically necessary for the requested procedure.

Pre-operative clearance per 05/26/15 order: 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) Low Back, Preoperative testing.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated service: Assistant surgeon per 05/26/15 order: 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 service: Cold therapy unit for the left shoulder per 05/26/15 order: 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, Continuous flow cryotherapy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-operative physical therapy, 3 times a week for 4 weeks, for the left shoulder per 05/26/15 order: 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.