

Case Number:	CM15-0128897		
Date Assigned:	07/20/2015	Date of Injury:	02/27/2014
Decision Date:	08/14/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	07/02/2015

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 was a 61 year old male, who sustained an industrial injury, February 27, 2014. The injured worker had fallen greater than 10 feet from a ladder while at work. The injured worker previously received the following treatments physical therapy for postoperative treatment of fracture pelvis, Hydrocodone, Docusate, Senokot, Gabapentin, Temazepam, Ecotrin, Percocet, Oxycontin, Aleve, Pamelor, Lexapro, lumbar spine MRI, cervical spine MRI, knee MRI, left foot x-rays, EMG/NCS (electrodiagnostic studies and nerve conduction studies) of the bilateral upper extremities showed bilateral medial nerve entrapment at the wrist (CTP carpal tunnel syndrome) affecting the predominantly the sensory fibers, right shoulder MRI. The injured worker was diagnosed with open reduction of a left pelvic fracture, cervical myofascial sprain/strain, lumbar sprain/strain, left acetabular fracture, internal derangement of the left knee, left fifth metatarsal neck fracture, chest wall contusion, rib fractures on the left, chronic bilateral L4 radiculopathy, bilateral carpal tunnel syndrome and right shoulder impingement syndrome rule out rotator cuff tear and right shoulder complete tear of the rotator cuff. According to progress note of May 26, 2015 the injured worker's chief complaint was right shoulder pain and weakness as well as headaches. The injured worker was complaining of left foot and ankle as well as low back pain. The injured worker had continued complaints of pain, numbness and tingling in the bilateral hands and wrists. The review of the right shoulder MRI on April 21, 2015, showed a complete tear of the supraspinatus tendon 25mm of tendinous retraction, infraspinatus tendinosis acromioclavicular osteoarthritis. The treatment plan included open rotator cuff repair, post-operative prescription for Norco, preoperative laboratory studies complete metabolic panel, chest ray, EKG (Electrocardiography), CBC (complete blood cell count), postoperative physical therapy, postoperative cryotherapy unit, surg-stim unit, postoperative, CPM (continuous range of motion machine).

IMR ISSUES, DECISIONS AND RATIONALES

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

Open right rotator cuff repair: Upheld

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

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, the injury is a delayed finding in the setting of significant trauma. Based on the records, there has not been a comprehensive non-surgical program for the right shoulder including therapy and injection management. Based on this, the request is not medically necessary.

Post op Norco 5/325mg #60: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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

Associated surgical service: CBC/CMP: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: Chest x-ray: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical services: EKG: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op Physical therapy x30 for the right shoulder: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op ultrasling: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op cryotherapy unit for purchase: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op SurgiStim unit for purchase: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op shoulder (CPM) rental for 4 weeks: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.