

Case Number:	CM15-0169705		
Date Assigned:	09/16/2015	Date of Injury:	11/20/2014
Decision Date:	11/06/2015	UR Denial Date:	08/04/2015
Priority:	Standard	Application Received:	08/28/2015

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 36-year-old female, who sustained an industrial injury on 11-20-14. Medical record indicated the injured worker is undergoing treatment for cervical disc disease, lumbar disc disease and right shoulder possible partial thickness rotator cuff tear, subacromial impingement syndrome and acromioclavicular joint pain and arthritis. Treatment to date has included cortisone injection of shoulder (which did not provide significant improvement), physical therapy, oral medications including Ibuprofen 800mg and activity modifications. On 5-1-15 she rated neck pain 6 out of 10, shoulder pain 6 out of 10 and back pain 6 out of 10. Currently on 7-20-15, the injured worker complains of continued shoulder, back and neck pain. Work status is noted to be modified duty. Physical exam performed on 6-29-15 and 7-20-15 revealed decreased sensation of right L4, 5 and S1 nerve distributions and global tenderness throughout the lumbar paraspinal muscles at L4-S1 with evidence of mild muscle spasms in the lower lumbar spine, cervical spine exam noted tenderness in the neck paraspinal muscles with pain at extremes of all range of motion, right shoulder exam noted mild evidence of scapulothoracic dyskinesia, cross arm adduction test is positive, and mild acromioclavicular joint pain on palpation and left shoulder exam is within normal limits. The treatment plan included request for diagnostic right shoulder arthroscopy with possible rotator cuff repair, possible labral repair, sub-acromial decompression and Mumford procedure, post-operative therapy 2 visits a week for 6 weeks, sling and 7-day rental of cryotherapy unit and continuation of Ibuprofen 800mg. On 8-4-15, utilization review non-certified right shoulder arthroscopy with possible rotator cuff repair, possible labral repair, sub-acromial decompression and Mumford procedure

noting the medical records failed to document an adequate course of conservative treatment, given the non-certification of the concurrent request, the use of the post-operative treatments is rendered non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with possible rotator cuff repair, possible labral repair, subacromial decompression and Mumford procedure: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workers' Compensation, Online Edition, 2015, Shoulder Chapter, Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter.

Decision rationale: According to the CA MTUS/ACOEM Guidelines, 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 imaging does not demonstrate full thickness rotator cuff tear. Therefore, the request is not medically necessary.

Associated Surgical Service: 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.

Associated Surgical Service: CBC: 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: BMP: 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: PT/PTT: 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: EKG: 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 arm 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: Seven day rental of a cyro 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.

Twelve post operative therapy sessions 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 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: Sequential compression device cuff (half leg out): 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.