

Case Number:	CM15-0092173		
Date Assigned:	05/18/2015	Date of Injury:	07/05/2013
Decision Date:	08/18/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	05/13/2015

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 57 year old female, who sustained cumulative industrial injuries from April 21, 2012 through July 5, 2013. She reported right knee pain, neck pain, right shoulder pain, right elbow pain and right hand pain with associated tingling and numbness. The injured worker was diagnosed as having status post right knee arthroscopy partialmedial and lateral meniscectomy, partial synovectomy and chondroplasty, right shoulder AC arthrosis, right shoulder impingement and right shoulder partial rotator cuff tear. Treatment to date has included diagnostic studies, surgical intervention of the right knee, conservative care, medications and work restrictions. MRI right shoulder 12/2/14 does not demonstrate a rotator cuff tear. Currently, the injured worker complains of continued neck pain, right shoulder, elbow and hand pain with associated tingling and numbness as well as right knee pain. The injured worker reported an industrial injury in 2001, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on January 21, 2015, revealed continued pain as noted. Electrodiagnostic studies of the cervical spine reportedly revealed no acute abnormalities of the cervical spine and moderate bilateral carpal tunnel syndrome. Magnetic resonance imaging of the right shoulder revealed arthrosis, impingement and a partial rotator cuff tear. Shoulder surgery, pre-operative clearance, diagnostic studies, post-operative physical therapy and equipment and shoulder sling was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with subacromial decompression debridement versus repair of the rotator cuff, possible distal clavicle resection: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for Rotator cuff repair.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 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 MRI of the right shoulder from 12/2/14 does not demonstrate evidence of a rotator cuff repair to warrant the surgical request. Therefore the determination is for non-certification for the requested procedure.

Pre-operative 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, Low Back, Preoperative testing.

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

Associated surgical service: Labs: Complete Metabolic Panel, PT, PTT, CBC, Electrolytes, BUN, Creatinine, Glucose and 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, Low Back, Preoperative testing.

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, Low Back, Preoperative testing.

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

Associated surgical service: Shoulder Sling with abduction pillow (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, Abduction pillow.

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

Associated surgical service: Polar Care Unit 1-2 week rental: 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 ODG Shoulder Chapter, Continuous flow cryotherapy.

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

Post-op Physical Therapy 2-3 week x 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.