

Case Number:	CM15-0092281		
Date Assigned:	05/18/2015	Date of Injury:	10/15/2014
Decision Date:	06/30/2015	UR Denial Date:	05/05/2015
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: Minnesota, Florida

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 47-year-old male who sustained an industrial injury on 10/15/14. Initial complaints included neck pain and muscle spasms. Initial diagnoses included cervical, thoracic, and right shoulder strain. Treatments to date have included physical therapy, massage therapy, and medication including muscle relaxants, narcotics, and non-steroidals. Diagnostic studies include x-rays, MRI of the cervical and thoracic spines, and a MRI of the right shoulder which showed a through and through supraspinatus tendon tear distally and anteriorly, and a superior labrum anterior posterior tendon tear. Current complaints include cervical, thoracic, and lumbar spine pain as well as bilateral shoulder pain, and issues related to headache, gastrointestinal, stress, psyche, and sleep. Current diagnoses include acute cervicothoracic strain, acute lumbar strain, acute thoracic bone bruise, and right shoulder rotator cuff tear, high grade partial. In a progress note dated 04/23/15 the treating provider reports the plan of care as a right shoulder arthroscopic rotator cuff repair and postoperative therapy, as well as a pain management consultation and possible cervical epidural steroid injection. The requested treatments include a right shoulder rotator cuff repair, postoperative physical therapy, and an arm sling. The request was non-certified by utilization review citing CA MTUS and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Rotator Cuff Repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-224. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211.

Decision rationale: The injured worker is a 47-year-old male with a history of neck and mid back injury on 10/5/2014 resulting from a motor vehicle accident. An MRI scan of the right shoulder dated 2/15/2015 revealed a focal through and through supraspinatus tendon tear distally and anteriorly at the insertion of the lateral crescent zone with adjacent bone marrow reactive change. The tear was partially filled with hypertrophic bursitis. Findings likely representing old internal impingement. No acute labral change identified. A SLAP lesion, likely type II was also reported. A progress note dated 5/14/2015 indicates that utilization review denied authorization for right shoulder rotator cuff repair for lack of conservative care. Only 3 sessions of physical therapy were approved preoperatively with minimal improvement. The provider requested additional physical therapy 2 times a week for 6 weeks for the right shoulder. The disputed issue is the request for a right shoulder rotator cuff repair with preoperative medical clearance, DME, and postoperative physical therapy. On examination, flexion and abduction of the right shoulder was 100 and internal and external rotation 60. Neer and Hawkins were positive. There was 4/5 strength in flexion, abduction, and external rotation. Neurologically both upper extremities were normal. The California MTUS guidelines indicate rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The preferred procedure is arthroscopic decompression. Surgery is not indicated for patients with mild symptoms or those whose activities are not limited. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. The documentation provided indicates 3 physical therapy sessions and no corticosteroid injections into the shoulder prior to the surgical request. A rotator cuff repair is indicated only after rehabilitation efforts have failed. As such, the request is not medically necessary.

Polar Care: 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 Physical Therapy (12-sessions, 2 times per 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.

Shoulder 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.