

Case Number:	CM13-0025817		
Date Assigned:	12/11/2013	Date of Injury:	08/09/2011
Decision Date:	11/14/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/18/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 42 year old female claimant had an industrial injury dated 08/09/11. MRI of 07/13/12 demonstrate no evidence of a rotator cuff tear, mild effusion with significant hypertrophy of the acromioclavicular joint, and supraspinatus tendinosis. Conservative treatments have included injections and physical therapy. The patient is status post a right shoulder surgery as of 06/28/13 including subacromial decompression and distal clavicle resection. Exam note 08/28/13 states that the patient continues to have shoulder pain. The patient demonstrates a decreased range of motion and decreased strength. It is noted that the patient recovered from the surgery slowly and with no improvement in pain relief. There is lack of documentation of current physical exam results and digital imaging. Diagnosis is noted as a joint derangement, disorders of bursae and tendons in the shoulder region along with a complete rupture of rotator cuff. Treatment includes a right shoulder arthroscopic superior labral repair and arthroscopic vs mini-open rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARTHROSCOPIC SUPERIOR LABRAL REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines SHOULDER COMPLAINTS Page(s): 209.

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, Labral Tear Surgery

Decision rationale: 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. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. In this case there is insufficient evidence to warrant labral repair secondary to lack of physical examination findings, lack of documentation of conservative care or characterization of the type of labral tear from the exam of 8/23/13. The request is not medically necessary and appropriate.

ARTHROSCOPIC VS MINI-OPEN ROTATOR CUFF REPAIR PROCEDURES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

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, 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 8/28/13 do not demonstrate 4 months of failure of activity modification. The physical exam does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. The MRI of the shoulder from 7/13/12 is essentially negative for rotator cuff tear. The request is not medically necessary and appropriate.