

Case Number:	CM13-0034097		
Date Assigned:	12/06/2013	Date of Injury:	10/19/2009
Decision Date:	04/24/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/11/2013

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:

The patient is a 49-year-old male who injured the left shoulder in a work-related accident on 10/19/09. A recent clinical assessment on 9/25/13 with the orthopedic provider documented ongoing complaints of pain in the left shoulder and noted that the claimant was status post rotator cuff repair and subacromial decompression performed in 2011. Physical examination showed positive impingement, positive drop-arm testing, and pain along the biceps with rotational movements. An MRI scan from 6/11/13 showed evidence of rotator cuff repair with tendinosis and a superior glenoid labral tear. Postoperative care since 2011 has included chiropractic care, acupuncture, medication management, and therapy. Other forms of conservative care were not noted. The recommendation was for revision arthroscopy, subacromial decompression, and labral repair with possible biceps tenodesis and rotator cuff repair was made.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPY WITH ACROMIOPLASTY, LABRAL REPAIR, POSSIBLE BICEP TENODESIS, AND POSSIBLE ROTATOR CUFF REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: Clinical records indicate continued complaints of pain, but no documentation of recent conservative measures that would include an injection that would be required to satisfy both sets of guideline criteria. The ACOEM and Official Disability Guidelines would not recommend the role of a surgical process to include a decompressive procedure or surgery for impingement in the absence of conservative care with injection therapy. Furthermore, the claimant's clinical imaging does not demonstrate re-tearing to the rotator cuff. There would be no indication for further rotator cuff procedures. The request is noncertified.

16 POST-OP PHYSICAL THERAPY SESSIONS: 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.