

Case Number:	CM13-0046861		
Date Assigned:	12/27/2013	Date of Injury:	06/18/2011
Decision Date:	03/06/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 reported an injury on 06/18/2011 due to carrying a heavy object. The patient reportedly sustained an injury to his left shoulder. Prior treatments included physical therapy and medications. The patient's most recent clinical examination findings included tenderness to palpation over the lateral acromion and supraspinatus with a positive impingement sign and weakness of the supraspinatus rated 4/10. It was noted within the documentation that the patient previously underwent an MRI that revealed evidence of a rotator cuff tendinosis, acromioclavicular joint degenerative changes, and a SLAP lesion. The patient's diagnoses included rotator cuff with partial thickness tearing, acromioclavicular joint degeneration, and labral tearing with associated paralabral cyst. The patient's treatment plan included surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) Left Shoulder Arthroscopy with Subacromial Decompression, Possible Rotator Cuff Repair, Mumford Procedure and Debridement, Superior Labrum Anterior Posterior (SLAP) Repair and Debridement of Paralabral Cyst: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

Decision rationale: The Physician Reviewer's decision rationale: The requested left shoulder arthroscopy with subacromial decompression, possible rotator cuff repair, Mumford procedure and debridement, superior labrum anterior posterior (SLAP) repair and debridement of paralabral cyst is not medically necessary or appropriate. American College of Occupational and Environmental Medicine recommends surgical intervention for patients who have clinical findings of significant deficits that would benefit from surgical intervention that are supported by an imaging study that have failed to respond to conservative treatments. Additionally, the American College of Occupational and Environmental Medicine only recommends surgical intervention for deficits that are significantly impairing the patient's ability to function. Although the clinical documentation submitted for review does provide evidence that the patient is having increasing pain complaints and there is evidence of impingement on physical examination, there is no documentation of how the patient's functional capabilities are significantly impaired by these deficits. Additionally, although it is noted within the documentation that the patient underwent an MRI, an independent review of that MRI was not submitted with the clinical documentation. Therefore, the need for surgical intervention cannot be determined. As such, the requested 1 left shoulder arthroscopy with subacromial decompression, possible rotator cuff repair, Mumford procedure and debridement, superior labrum anterior posterior (SLAP) repair and debridement of paralabral cyst is not medically necessary or appropriate

Pre-Operative Medical Clearance by an Internist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The Physician Reviewer's decision rationale: The requested preoperative medical clearance by an internist is not medically necessary or appropriate. Official Disability Guidelines do not recommend routine preoperative testing in the absence of a diagnosis that could cause intraoperative or postoperative complications. The clinical documentation submitted for review does not provide any evidence that the patient is at risk for any postoperative or intraoperative complications. Additionally, the concurrent request for surgical intervention is not supported by the documentation. As such, the requested decision for preoperative medical clearance by an internist is not medically necessary or appropriate.

Surgical Assistant: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Surgeons, Physicians as Assistant Surgeons, 2011 Case Study.

Decision rationale: The requested surgical assistant is not medically necessary or appropriate. American College of Surgeons, a 2011 case study of physicians as assistant surgeon's states that an assistant surgery is almost always needed for the requested surgical intervention. However, the concurrent request for surgical intervention is not supported by the documentation. As such, the requested 1 surgical assistant is not medically necessary or appropriate.

Twelve (12) Post-Operative Physical Therapy Visits: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The Physician Reviewer's decision rationale: The requested 12 postoperative physical therapy sessions is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend an initial course of therapy of 12 physical therapy sessions as appropriate treatment for this type of surgery. However, the concurrent request for surgical intervention is not supported by the documentation submitted. As such, the requested 12 postoperative physical therapy visits is not medically necessary or appropriate.