

Case Number:	CM13-0071378		
Date Assigned:	01/08/2014	Date of Injury:	02/06/2013
Decision Date:	04/11/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	12/27/2013

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 Pennsylvania. 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 55-year-old male who sustained an injury to the left shoulder on 2/6/13. The clinical records for review included a recent right shoulder MRI report dated 4/6/13 that showed evidence of rotator cuff tendinopathy with partial thickness articular sided tearing, biceps tendinosis and acromioclavicular osteoarthritis. SLAP lesion(s) was not able to be excluded, but also not able to be identified. The recent clinical assessment dated 8/5/13 noted ongoing complaints of pain in the claimant's right shoulder. Physical examination of the right shoulder showed restricted range of motion, tenderness to palpation and diminished strength. The left shoulder examination showed tenderness to palpation over the bicipital groove and AC joint. The claimant's working diagnosis was tendinosis of the bilateral shoulders. Recommendations were for surgery for the right shoulder described as arthroscopy and repair. At present, there is a request for left shoulder arthroscopy and repair. A follow-up report dated 12/16/13 documented diminished motor strength of 4/5 to the right shoulder and tenderness over the left shoulder with impingement. Once again, a left shoulder arthroscopy and rotator cuff repair with 12 sessions of postoperative physical therapy and a left shoulder radiograph were recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy and repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

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

Decision rationale: Based on the California MTUS/ACOEM guidelines, left shoulder arthroscopy and repair cannot be recommended as medically necessary. The records in this case do not indicate full thickness rotator cuff tearing to the left shoulder on MRI. There is also no documentation that conservative treatment has included injection therapy. The lack of the above information would fail to necessitate the acute need of a shoulder arthroscopy and repair given the claimant's current clinical setting.

Postoperative physical therapy twice a week for six weeks for the left shoulder: 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.

An x-ray for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines

Decision rationale: Based on the California MTUS/ACOEM guidelines and the Official Disability Guidelines, the request for plain films/radiographs of the left shoulder would not be indicated. It is not clear from the records provided for review when the previous radiographs were taken. This information, as well as the reports of the films, would be necessary prior to determining whether a new set of x-rays were necessary. Due to the lack of documentation of the previous x-rays of the left shoulder, a new set of left shoulder x-rays cannot be recommended. While surgery is being requested, it is unclear how a new plain film radiograph would add to the discussion regarding the claimant's left shoulder and absence of recent conservative measures. The request is non-certified.