

Case Number:	CM14-0007088		
Date Assigned:	02/07/2014	Date of Injury:	10/06/2012
Decision Date:	06/23/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/18/2014

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, has a subspecialty in Hand 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 claimant, a 39-year-old gentleman, injured his left shoulder on 10/06/12. The report of a 3/19/13 MRI of the left shoulder identified partial thickness complete bursal surface supraspinatus tendon tearing with superior humeral migration resulting in impingement. The follow up visit of 12/05/13, noted continued complaints of pain in the left shoulder and documented conservative treatment consisted of an extensive course of formal physical therapy, anti-inflammatory medications, and several corticosteroid injections. Examination was documented to show acromioclavicular joint tenderness to palpation, positive acromioclavicular joint stress testing, restricted range of motion, positive O' Brien's test, tenderness at the bicipital groove, and positive Neer, Hawkin's, and Jobe impingement testing. Based on failed conservative care, shoulder arthroscopy, subacromial decompression, distal clavicle resection, and possible rotator cuff repair procedure was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARTHROSCOPIC ROTATOR CUFF REPAIR, ACROMIOPLASTY AND DISTAL CLAVICLE RESECTION AND LEFT SHOULDER ROTATOR CUFF REPAIR:

Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004) , 9, 210-211

Decision rationale: Based on California ACOEM Guidelines and supported by the Official Disability Guidelines, the request for left shoulder arthroscopic rotator cuff repair, acromioplasty, and distal clavicle resection is recommended as medically necessary. The imaging report identifies a high grade partial thickness tearing of the rotator cuff and the claimant has failed to improve with conservative care and continues to have positive examination findings. There is documentation of six months of positive conservative care with no symptomatic long term relief. The role of operative intervention to include acromioplasty distal clavicle resection rotator cuff assessment in this individual with high grade rotator cuff pathology would be supported. The request for Arthroscopic Rotator Cuff Repair, Acromioplasty and Distal Clavicle Resection and left shoulder Rotator Cuff Repair is medically necessary and appropriate.