MAXIMUS Federal Services

Case Number:	CM14-0009197		
Date Assigned:	02/14/2014	Date of Injury:	03/01/2012
Decision Date:	06/24/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/23/2014

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 Sports Medicine 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 claimant injured his right shoulder in a work-related motor vehicle accident on March 1, 2012. The report of an MRI of the right shoulder dated October 28, 2012 showed partial thickness rotator cuff tearing, acromioclavicular joint arthropathy, evidence of impingement and a subchondral cyst of the humeral head. The December 18, 2013 follow up report specific to the right shoulder noted complaints of pain despite a recent corticosteroid injection that provided short term relief, however, symptoms were now returning. Examination showed restricted motion with abduction and flexion to 100 degrees, pain with resisted abduction and no other findings. Plain film radiographs revealed AC joint arthropathy with a type II acromion. The report documents that conservative care has included a corticosteroid injection, therapy, medication and work restrictions. The recommendation was made for surgery to consist of rotator cuff repair, synovectomy, subacromial decompression and distal clavicle excision.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ROTATOR CUFF REPAIR: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

Decision rationale: California ACOEM Guidelines support the request for surgery for partial thickness rotator cuff tearing. This individual has failed conservative care for greater than six months including injection therapy. The claimant continues to have symptoms consistent with high grade impingement. Therefore, the request for right should rotator cuff repair is medically necessary and appropriate.

SYNOVECTOMY: Overturned

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

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

Decision rationale: Based on California ACOEM Guidelines, a synovectomy during the above procedure also would be supported. This individual has failed conservative care for which operative intervention is currently supported. Therefore, the request for synovectomy is medically necessary and appropriate.

SUBACROMIAL DECOMPRESSION: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

Decision rationale: California ACOEM Guidelines also would support the role of a subacromial decompression. This individual's physical examination, imaging, and prior conservative care are consistent with the need for operative intervention for the diagnosis of impingement. Therefore, the request for subacromial decompression is medically necessary and appropriate.

DISTAL CLAVICLE RESECTION: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER PROCEDURE -PARTIAL CLAVICULECTOMY (MUMFORD PROCEDURE)

Decision rationale: The CA MTUS and ACOEM Guidelines do not address this request. When looking at Official Disability Guidelines, the request for distal clavicle excision would also be supported. The proposed surgery in this case has been supported by clinical records including prior MRI, physical examination and past conservative care. This individual has degenerative pathology at the distal clavicle on both MRI scan and plain film radiographs. Therefore, the request for distal clavical resection is medically necessary and appropriate.