

Case Number:	CM14-0009438		
Date Assigned:	02/14/2014	Date of Injury:	01/21/2005
Decision Date:	07/24/2014	UR Denial Date:	01/04/2014
Priority:	Standard	Application Received:	01/24/2014

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 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:

This 45-year-old caregiver sustained an industrial injury on 1/21/05 when she tripped on a flight of stairs while carrying a vacuum. The patient underwent multiple left knee surgeries, including left patellar arthroplasty on 5/16/11. The patient underwent right shoulder arthroscopy, glenohumeral joint synovectomy, superior labral debridement, rotator cuff repair, and platelet-rich plasma autography on 9/28/09. Past medical history is positive for diabetes. The 11/17/13 progress report cited right shoulder pain isolated to the area under the deltoid and within the axilla. The 10/17/13 right shoulder MRI demonstrated an intact rotator cuff repair and a probable Type 2 SLAP tear. Right shoulder exam findings noted pain over the bicipital groove with direct palpation, normal shoulder range of motion, and positive Speed, Yergason's and O'Brien's tests. The diagnosis was right shoulder long head of the biceps tendonitis and status post rotator cuff repair. The treatment plan requested subacromial and glenohumeral joint platelet-rich plasma injections. The 12/17/13 progress report cited right shoulder pain, primarily in the front, axillary pain, and pain with forward elevation and to the side. Right shoulder exam documented flexion and abduction limited to 90 degrees, external rotation 70 degrees, and internal rotation 60 degrees, and extension 40 degrees with pain at each limited. The patient has tenderness along the intertubercular sulcus with a positive speed and O'Brien, and 4/5 right shoulder girdle strength with pain in all directions. The treatment plan requested right shoulder arthroscopy, biceps tenodesis, possible debridement, possible rotator cuff repair, SLAP debridement or repair, and possible subacromial decompression. The 1/3/14 utilization review denied the surgical request as the specific guidelines for each procedure had not been met, range of motion and strength had been reported normal until the most recent visit,, no physical therapy had been provided for the shoulder, injections had not been attempted, and imaging had not proven a lesion indicative of

immediate surgical intervention. The 1/29/14 appeal letter stated that he was requesting possible procedures that would be determined at the time of surgery as MRI results are not 100%.

IMR ISSUES, DECISIONS AND RATIONALES

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

A RIGHT SHOULDER ARTHROSCOPY, POSSIBLE BICEPS TENODESIS, ROTATORS CUFF REPAIR, DEBRIDEMENT, AND POSSIBLE SLAP DEBRIDEMENT REPAIR WITH POSSIBLE SUBACROMIAL DECOMPRESSION: 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), Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Diagnostic Arthroscopy, Surgery for rotator cuff repair, Surgery for SLAP lesions.

Decision rationale: The California MTUS guidelines do not provide recommendations for shoulder surgery in chronic cases. The Official Disability Guidelines state that diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. The ODG for biceps tenodesis state that nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendon. Guidelines state that consideration of a tenodesis should increase evidence of an incomplete tear. The ODG for rotator cuff repair generally require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Guideline criteria have not been met. There is no evidence that this patient is experiencing acute pain. There has been recent documentation of a loss of range of motion and strength in the 12/17/13 progress report that had not been documented in previous reports dating back to 12/5/12. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment to the right shoulder had been tried and failed. There is no indication that imaging is inconclusive. Therefore, this request for the surgical procedure is not medically necessary.

GENERAL ANESTHESIA: 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.

INTRAVENOUS LACTATED RINGERS AT KVO: 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.