

Case Number:	CM14-0102889		
Date Assigned:	09/24/2014	Date of Injury:	01/18/2013
Decision Date:	10/24/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/03/2014

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 48-year-old male route driver sustained an industrial injury on 1/18/13. Injury occurred when he tried to reach for a battery from the top shelf. The 8/22/13 left shoulder MRI findings documented mild rotator cuff tendinosis with no evidence of a full thickness tear or retraction. There was a Type 1 lateral downsloping acromion and severe acromioclavicular joint degenerative change. A SLAP lesion was seen extending to but not avulsing the biceps anchor with split biceps tendon or partial longitudinal tear in the bicipital groove. There were minimal glenohumeral degenerative changes. Records indicated the patient had persistent moderate left shoulder pain. Conservative treatment included anti-inflammatory medications, TENS unit, activity modification, physical therapy and corticosteroid injection. The 4/29/14 treating physician report cited no significant improvement with corticosteroid injection. Physical exam documented limited range of motion with positive impingement signs. The diagnosis was chronic left shoulder impingement with partial thickness rotator cuff tear. The treatment plan recommended left shoulder arthroscopic subacromial decompression. The 5/12/14 physical therapy note indicated the patient had completed 12 visits of physical therapy for the left shoulder. The left shoulder remained limited in range of motion and strength but passive range of motion was maintained. The 6/25/14 utilization review denied the left shoulder surgery and associated requests as there was no evidence that guideline-recommend conservative treatment had been carried out for 3 to 6 months, a full thickness tear was not established, and clinical impingement signs were not documented on physical exam.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic subacromial decompression: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) shoulder

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The California MTUS guidelines provide general recommendations for rotator cuff repair and impingement syndrome. For rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for three months. The preferred procedure is arthroscopic decompression. Guideline criteria have been met. This patient presents with subjective and clinical findings of impingement, consistent with imaging findings of rotator cuff and labral pathology with severe acromioclavicular joint degenerative changes. Evidence of at least 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is medically necessary.

Post-op Physical Therapy 3x4: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for impingement syndrome suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.