

Case Number:	CM14-0016423		
Date Assigned:	06/11/2014	Date of Injury:	08/20/2008
Decision Date:	07/28/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/10/2014

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 Texas. 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 injured worker is a 70-year-old female who reported an injury on 08/20/2008. The injured worker underwent an MRI of the right shoulder on 11/20/2013 which revealed the injured worker had a flat laterally down-sloping acromion. The acromioclavicular joint revealed arthritis. The injured worker had a full-thickness tear at the distal insertion of the supraspinatus measuring 7.6 x 14.8 mm. The injured worker had muscle atrophy. The injured worker had tendinosis in the infraspinatus. The injured worker had a Bankart lesion. The injured worker had a superior dislocation of the humerus and an effusion in the synovium. The injured worker had subacromial and subdeltoid bursal fluid. The mechanism of injury was a severe twisting injury. The injured worker underwent surgery on 01/13/2012. The documentation of 12/26/2013 revealed the injured worker had complaints of right shoulder pain and weakness. The injured worker could not perform overhead activities secondary to pain and could not sleep. The injured worker complained of loss of motion of the shoulder. The examination of the right shoulder revealed the injured worker had abduction of 160 degrees, internal rotation of 20 degrees, and extension and adduction of 20 degrees. The injured worker had decreased grip strength. The motor strength revealed 4+/5 in the right supraspinatus. The deep tendon reflexes were 2+. The injured worker had a positive impingement 1 and 2 test as well as a drop arm test. The injured worker underwent x-rays of the shoulder and humerus which showed spurring on the undersurface of the acromion. The treatment plan included a diagnostic and operative arthroscopy of the right shoulder with rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

DX/OPA RIGHT SHOULDER WITH REPAIR OF LARGE ROTATOR CUFF TEAR:
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Surgery for rotator cuff repair, Diagnostic Arthroscopy.

Decision rationale: The ACOEM Guidelines indicate that a referral for surgical consultation may be appropriate for injured workers who have red flag conditions, activity limitation for more than 4 months, plus the existence of a surgical lesion and a failure to increase range of motion and strength of musculature around the shoulder even after an exercise program, plus existence of a surgical lesion on imaging and clear clinical objective findings. Additionally, ACOEM indicates that for small full-thickness tears, surgery is reserved for cases failing conservative therapy of 3 months. However, the injured worker had a large tear. As such additional guidelines were sought. The Official Disability Guidelines indicate that the criteria for rotator cuff repair with the diagnosis of a full-thickness rotator cuff tear in appropriate when cervical pathology and frozen shoulder syndrome have been ruled out. There should be documentation of shoulder pain and an inability to elevate the arm, tenderness over the greater tuberosities, and in most cases the injured worker may have weakness with abduction and may demonstrate atrophy of the shoulder musculature. There should be conventional x-rays, AP, and true lateral or axillary views, and gadolinium MRI that shows evidence of a deficit in the rotator cuff. The injured worker showed MRI evidence of rotator cuff deficit. However, there was a lack of documentation indicating the injured worker had x-rays of the shoulder and humerus which showed evidence of a deficit in the rotator cuff. Additionally, there was a lack of documentation indicating cervical pathology and frozen shoulder syndrome had been ruled out. The California MTUS and ACOEM guidelines do not address diagnostic arthroscopies. As such, secondary guidelines were sought. The Official Disability Guidelines recommends diagnostic arthroscopies when the MRI is inconclusive. The MRI revealed a tear. Given the above, the request for DX/OPA right shoulder with repair of large rotator cuff tear is not medically necessary.

POST OPERATIVE PHYSICAL THERAPY 12 SESSIONS: 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.

POST OPERATIVE DURABLE MEDICAL EQUIPMENT (DME) COLD THERAPY UNIT FOR 7 DAY RENTAL/PURCHASE: 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.

POST OPERATIVE DURABLE MEDICAL EQUIPMENT (DME) SHOULDER IMMOBILIZER, PURCHASE: 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.

POST OPERATIVE DURABLE MEDICAL EQUIPMENT (DME) PAIN PUMP PERCHASE: 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.

POST OPERATIVE ELECTRICAL STIM UNIT FOR 2 WEEKS RENTAL/PURCHASE: 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.

POST OPERATIVE DURABLE MEDICAL EQUIPMENT (DME) CPM MACHINE FOR 30 DAYS RENTAL: 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.