

Case Number:	CM14-0116390		
Date Assigned:	08/04/2014	Date of Injury:	01/27/2014
Decision Date:	09/10/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/23/2014

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 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 60-year-old female cafeteria worker sustained an industrial injury on 1/27/14. Injury occurred when she slipped and fell in a walk-in freezer. The 3/8/14 right shoulder MRI impression documented degenerative changes. The 6/18/14 initial treating physician report cited constant right shoulder pain aggravated by overhead work, flexion, abduction, lifting, carrying, pushing, and pulling. Physical exam documented marked loss of right grip strength, 2/5 right deltoid strength, and 3/5 right shoulder flexor strength. There were moderate to marked right sided paracervical, trapezius, and rhomboid tenderness and spasms. Right shoulder exam documented marked subacromial tenderness and positive impingement sign. Range of motion testing demonstrated flexion 120, abduction 110, internal rotation 50, and external rotation 70 degrees. Shoulder x-rays showed early degenerative changes of the glenohumeral joint. A right shoulder corticosteroid injection was recommended but the patient refused. Conservative treatment had included 8 sessions of physical therapy, medications, and modified work. The 7/9/14 treating physician report cited intermittent right shoulder pain. Physical exam documented moderate subacromial tenderness with clicking and pain. Range of motion was limited to 120 degrees flexion/abduction. Shoulder abduction weakness was documented. The 3/8/14 MRI scan reportedly revealed that the patient had tearing of the supraspinatus tendon not mentioned by the radiologist. Based on the on-going symptoms and loss of range of motion despite extensive conservative treatment, right shoulder arthroscopy with rotator cuff repair requested. The patient was placed off work. The 7/16/14 utilization review denied the request for right shoulder surgery as imaging criteria were not met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder video arthroscopy with debridement and rotator cuff repair: Upheld

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

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

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines for rotator cuff repair of partial thickness tears 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 detailed documentation that comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Imaging evidence of a rotator cuff tear was not documented by the radiologist. A diagnostic injection test has not been performed. Therefore, this request is not medically necessary.

Assistant surgeon: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Centers for Medicare and Medicaid services, Physician Fee Schedule.

Decision rationale: As the requested surgery is not medically necessary, this request is also not medically necessary.

Pre-operative laboratory work (blood and urine): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

Decision rationale: As the requested surgery is not medically necessary, this request is also not medically necessary.

EKG (electrocardiogram): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

Decision rationale: As the requested surgery is not medically necessary, this request is also not medically necessary.

Post-operative physical therapy, three (3) times weekly for four (4) weeks: Upheld

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

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

Decision rationale: As the requested surgery is not medically necessary, this request is also not medically necessary.