

Case Number:	CM14-0132373		
Date Assigned:	09/19/2014	Date of Injury:	07/12/2011
Decision Date:	11/05/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/19/2014

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 Hand 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 38-year-old male who reported an injury on 07/12/2011. The mechanism of injury was not submitted for clinical review. The diagnoses included right shoulder possible rotator cuff tear, right shoulder possible labral tear, right shoulder impingement sign, left knee meniscal tear, and status post left knee arthroscopy, and left knee chondromalacia. The previous treatments included medication, surgery, and physical therapy. The diagnostic testing included a right shoulder MRI dated 07/17/2014. Within the clinical note dated 07/30/2014, it was reported the injured worker complained of pain in his right shoulder. He complained of difficulty lifting and reaching behind his back and his side. On the physical examination, the provider noted the right shoulder revealed impingement. There was weakness with external rotation and abduction. Forward flexion was noted to be 150 degrees and external rotation was 45 degrees. There was pain with anterior/posterior translation. The MRI of the right shoulder revealed mild supraspinatus/infraspinatus tendinosis and mild to moderate bursal fraying. There was no evidence of a transmural tear. There was disruption of the superior labrum extending anteriorly and posteriorly. The provider requested a right shoulder arthroscopy, subacromial decompression, repair of rotator cuff, and repair of the labrum; postoperative physical therapy; postoperative DME; an abduction sling; a Polar Care unit; and CPM rental. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY ROTATOR CUFF REPAIR, SUBACROMIAL DECOMPRESSION, LABRUM REPAIR: Upheld

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): 210-211.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for Slap Lesion.

Decision rationale: The request for right shoulder arthroscopy rotator cuff repair, subacromial decompression, labrum repair is not medically necessary. The California MTUS/ACOEM Guidelines note rotator cuff repair is indicated for significant tears that impair activities by causing weakness of the arm elevation and rotation, particularly acutely in younger workers. Rotator cuff tears are frequently partial thickness or smaller full thickness tears. For partial thickness rotator cuff tears and small thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The preferred procedure is usually arthroscopic decompression, which involves debridement of inflamed tissues, burning of the anterior acromion, lysis, sometimes removal of the coracoacromial ligament, and possibly removal of the outer clavicle. Surgery is not indicated for patients with mild symptoms and those whose activities are not limited. The Official Disability Guidelines note surgery is recommended for type II lesions and for type IV lesions if more than 50% of the tendon is involved. Generally, type I and II lesions do not need any treatment and are debrided. The guidelines recommend surgical intervention after 3 months of conservative care when the patient's history and physical examination and imaging indicate pathology. Definitive diagnosis of a SLAP lesions may be made during diagnostic arthroscopy. The clinical documentation submitted did indicate the injured worker had surface fraying of the supraspinatus tendon and mild articular surface fraying of the infraspinatus tendon and there was disruption of the superior labrum extending anteriorly and posteriorly. While debridement and labrum repair may be indicated, there is no evidence of a rotator cuff tear. However, the imaging studies did not corroborate the finding of a rotator cuff tear. Additionally, the clinical documentation did not have a definitive diagnosis of a SLAP lesion. Therefore, the request is not medically necessary..

POST OP PT 3 X 4 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the request is not medically necessary.

POST OP DME: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the request is not medically necessary.

ABDUCTION SLING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the request is not medically necessary.

POLAR CARE UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the request is not medically necessary.

CPM RENTAL FOR 21 DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the request is not medically necessary.