

Case Number:	CM14-0168819		
Date Assigned:	10/16/2014	Date of Injury:	10/13/2006
Decision Date:	11/19/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/13/2014

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 case involves a 57-year-old male with who reported an industrial injury on October 13, 2006. The injured worker is status post left shoulder superior labrum anterior posterior revision on 2/14/2008 and 4/24/2008. The patient is status post left shoulder arthroscopy, rotator cuff repair, extensive debridement and PRP injection of blood harvest on 12/9/2009 and 12/2/2010. The patient is status post left shoulder rotator cuff repair, revision with removal of hardware with bone allograft placement. As well as, soft tissue allograft for rotator cuff reinforcement and extensive debridement, PRP, blood harvest and hardware removal on July 26, 2012. MR arthrogram of the left shoulder from 7/24/2014 demonstrates persistent full-thickness left super spinatus tear near its attachment to the left greater tuberosity measuring 2.8 cm in length. Extensive postoperative changes involving the left humeral head and glenoid labrum are noted. Exam note from June 18, 2014, demonstrates active range of motion of 0 to 135 of forward flexion, 70 of internal rotation. Exam noted a 22,014 demonstrates significant worsening of the rotator cuff tear. Request is made for reconstruction and PRP Injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: left shoulder arthroscopy with superior capsular reconstruction with allograft, PRP injection and assistant surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Diagnostic Arthroscopy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. In this case the MRI from 7/24/14 does not demonstrate a clear lesion shown to benefit from surgical repair. The patient has had extensive surgery with postsurgical changes and the degree of osteoarthritis is not known. Therefore, this request is not medically necessary.

Associated surgical service: preoperative medical clearance EKG, CBC, renal function panel: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: postoperative, sling, cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pre-Operative Testing, General

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: postoperative physical therapy 1 to 2 times a week, time 8 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.