

Case Number:	CM14-0176347		
Date Assigned:	10/29/2014	Date of Injury:	04/11/2012
Decision Date:	12/10/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/24/2014

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 is a 50-year-old male claimant with reported industrial injury date of 4/11/12. Exam note demonstrates continued right shoulder pain. Objective findings include positive Hawkin's sign. Diagnosis is acromioclavicular joint arthropathy, right shoulder with impingement syndrome, right shoulder with possible tear of labrum right shoulder. Exam note 09/30/14 demonstrates pain in right shoulder. MR arthrogram right shoulder demonstrates type 2 SLAP tear extending into the biceps anchor, partial tear of right superior glenohumeral ligament and intact right rotator cuff with mild osteoarthritis of the right AC joint. Objective findings include decreased range of motion in right shoulder, tender AC joint, with painful arc of motion from 70-120 degrees, negative Speeds test. Plan is right shoulder arthroscopy with labral resection or repair, SAD and possible repair of the glenohumeral ligament. Physical therapy is recommended post-operatively.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with Labral Resection or Repair with Subacromial Decompression Acromioplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 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, Acromioplasty Surgery

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 9/30/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 9/30/14 does not demonstrate evidence satisfying the above criteria except for painful arc of motion. There is lack of demonstration of failure of 3-6 months of non-operative therapy. Therefore, this request is not medically necessary.

Repair Slap Lesion: 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: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Labral Tear Surgery

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. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. In this case there is insufficient evidence to warrant labral repair secondary to lack of physical examination findings, lack of documentation of 3-6 months of conservative care in the records from 9/30/14. Therefore, this request is not medically necessary.

Post-Operative Physical Therapy: 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.

Complete Blood Count: 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.