

Case Number:	CM14-0182063		
Date Assigned:	11/06/2014	Date of Injury:	10/25/2010
Decision Date:	12/09/2014	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/03/2014

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 Minnesota. 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 24 year old female with a history of left shoulder and neck pain from repetitive motion trauma since 10/25/2010. She underwent MRI scans of the cervical spine and the left shoulder in October 2011. The cervical MRI revealed a small left sided protrusion at C5-6. The shoulder MRI revealed rotator cuff tendinosis with a partial thickness tear of the supraspinatus tendon and a SLAP lesion. EMG was negative for radiculopathy. A corticosteroid injection into the subacromial space did not relieve the pain. A repeat MRI of 6/7/2013 revealed mild to moderate tendinosis with partial thickness tear of the supraspinatus with bursitis, downsloping acromion, and degenerative change in the acromioclavicular joint. On 10/8/2013 arthroscopic subacromial decompression was performed but there was no improvement despite post-operative physical therapy. A chronic pain syndrome was treated with opioids in a pain management clinic. On 7/2/2014 an MR Arthrogram of the shoulder was entirely negative. The disputed issue pertains to the need for additional surgery consisting of inferior capsular shift and capsular plication. Ancillary services are also requested. No history of shoulder dislocations is documented. There is no apprehension sign on examination. No instability is documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder inferior capsular shift, capsular plication: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery- Shoulder dislocation surgery

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213, 214.

Decision rationale: California MTUS guidelines indicate consideration for surgery when there is clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. Surgical considerations depend upon confirmation of the clinical diagnosis by imaging studies. Such is not the case here. The MR Arthrogram of the left shoulder of 7/2/2014 was entirely negative. There is no evidence of instability. There is no SLAP lesion and no impingement present. The rotator cuff is intact. The previous shoulder decompression was performed despite lack of response to a corticosteroid injection of the subacromial space and failed to relieve her pain because there was no impingement. There is a history of chronic pain syndrome involving the neck and shoulder with no objective evidence of a lesion that can benefit from surgical intervention. The UR denial was based upon absence of a history of shoulder dislocations or findings of a positive apprehension test or other evidence to indicate the medical necessity of the inferior capsular shift or plication. Her complaint is that of constant shoulder pain and not instability. The documentation does not support disabling instability necessitating a capsular shift. The medical necessity of the requested surgery is therefore not established per guidelines.

Pre op surgical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-214.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Cold therapy unit x 7 day rental: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-214.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Immobilizer sling with pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-214.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post op PT x 12 sessions for the left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-214.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.