

Case Number:	CM14-0031853		
Date Assigned:	06/20/2014	Date of Injury:	11/26/2000
Decision Date:	07/17/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/13/2014

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 62-year-old female sustained an industrial injury on 11/25/00 relative to a slip and fall. The patient is status post two left shoulder surgeries. The 5/21/13 treating physician report cited continued severe symptoms, and opined the clear need for rotator cuff reconstruction. She had pain and weakness. The 2/3/14 treating physician report indicated that patient has had on-going symptoms since her last visit on 4/9/13. Pain had gotten worse, she could not lift, push or pull, and she had a lot of night pain. Physical exam findings documented forward elevation to 90 degrees, external rotation 70 degrees, and internal rotation 60 degrees, there was crepitus with motion. There was 4/5 abduction and external rotation weakness on the left. Upper extremity sensation and reflexes were intact. X-rays showed 3 metal suture anchors in the greater tuberosity, mild inferior spurring, and she was not riding fairly tight. The impression was on-going chronic left shoulder rotator cuff tear. The treating physician stated the patient had two surgeries on the left, the last one failed. She has a tear about the supraspinatus and mild infraspinatus involvement. She did not have any strong fatty infiltrates. He opined the medical necessity of surgery. The 2/25/14 utilization review denied the request for left shoulder rotator cuff revision surgery and associated services as there was no independent imaging for review, no prior operative reports, and no documentation of any recent attempts at conservative treatment. There appeared to be a treatment gap between April 2013 and February 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder rotator cuff revision surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, SURGERY FOR ROTATOR CUFF REPAIR.

Decision rationale: Under consideration is a request for left shoulder rotator cuff revision surgery. The California MTUS does not provide recommendations for surgeries in chronic shoulder conditions. The Official Disability Guidelines for rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment. Subjective criteria include pain with active arc of motion 90 to 130 degrees and pain at night. Objective criteria include weak or absent abduction and tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of rotator cuff deficit are required. Guidelines state that the results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. Guideline criteria have not been met. There is no current documentation of a positive impingement sign with positive diagnostic injection test. There is no current MRI report available for assessment of rotator cuff tissue and intact deltoid origin. The patient does not have elevation above horizontal and is status post more than one prior procedure. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for left shoulder rotator cuff revision surgery is not medically necessary.

Preop Internal Medicine consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127.

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: INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT (ICSI). PREOPERATIVE EVALUATION.

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

Postop Physical Therapy 3x6: Upheld

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

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

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