

Case Number:	CM14-0033262		
Date Assigned:	07/11/2014	Date of Injury:	09/29/2011
Decision Date:	08/13/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/17/2014

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 Physical Medicine & Rehabilitation 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:

The injured worker is a 48-year-old male who reported an injury on 09/29/2011. The mechanism of injury was that the injured worker was lifting cartons of shoes. Prior conservative care included activity modification, medications, injections, physical therapy and acupuncture. The injured worker underwent an arthroscopic right rotator cuff repair and right arthroscopic glenohumeral debridement on 05/03/2012 as well as postoperative physical therapy. On 05/02/2013, the injured worker subsequently underwent a left shoulder arthroscopy with repair of the supraspinatus tendon, cervical decompression and debridement. It was documented that the injured worker did not perceive any benefit from that surgery. The injured worker had an x-ray on 12/04/2013, which revealed that there was 1 anchor in the right shoulder and 2 anchors in the left shoulder. It was indicated that otherwise, the radiographic examination was normal. The most recent documentation was 05/06/2014, which revealed that the injured worker had no tenderness to palpation in the biceps tendon or biceps. There was tenderness to palpation about the lateral aspect of the deltoids. There was intact sensation to light touch and equivalent bilaterally in the radial, median and ulnar nerve distributions. It was indicated that the injured worker was 6 weeks post open rotator cuff repair. The injured worker had a left rotator cuff repair, acromioplasty and biceps tenodesis on 03/17/2014. The documentation of 02/25/2014 revealed that the injured worker had active forward flexion on the right of 50 degrees and on the left at 60 degrees. The injured worker had active abduction on the right of 65 degrees and on the left of 70 degrees. Active external rotation was 40 degrees on the right and 50 degrees on the left. It was indicated that the injured worker was able to place his hands on the top of his head with the elbow held forward. The muscle strength testing was 4/5 bilaterally in forward flexion and abduction as well as Jobe's abduction. The injured worker had a negative lift off and a negative belly press sign bilaterally. The documentation indicated that the injured worker had an

MRI, which demonstrated the previous insertion of the metallic suture anchor and that the injured worker had a supraspinatus tear in the anterior 2/3 of the tendon. It was noted to have retracted to the center of the humeral head. The treatment plan included that the injured worker had a repeat tear of his left shoulder rotator cuff tendon, and it had retracted to the point where they may not be able to perform the procedure arthroscopically. It was indicated that the injured worker most likely would have to have the shoulder repaired in an open fashion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Open Rotator Cuff Repair versus possible reversed shoulder arthroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

MAXIMUS 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, Arthroplasty.

Decision rationale: The ACOEM Guidelines indicate that surgical consultations may be appropriate for injured workers who have red flag conditions, activity limitations for more than 4 months and a failure to increase range of motion and strength of the musculature around the shoulder as well as clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. The clinical documentation submitted for review indicated that the injured worker had objective findings upon physical examination. The documentation indicated that the injured worker had an MRI. However, the MRI was not provided for review. This portion of the request would not be supported. The Official Disability Guidelines indicate that shoulder arthroplasty is appropriate for injured workers who have glenohumeral and acromioclavicular joint osteoarthritis, post-traumatic arthritis or rheumatoid arthritis. The clinical documentation submitted for review failed to indicate that the injured worker had osteoarthritis in the shoulder joint. Given the above, the request for a left shoulder open rotator cuff repair versus a possible reversed shoulder arthroplasty is not medically necessary.

Assistant Surgeon: 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.

Two day inpatient hospital stay.: 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.