

Case Number:	CM14-0045062		
Date Assigned:	08/06/2014	Date of Injury:	02/22/2010
Decision Date:	10/10/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/14/2014

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 Texas. 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 55-year-old male with a reported date of injury of 02/22/2010. The mechanism of injury was noted to be from cumulative trauma. His diagnoses were noted to include full thickness rotator cuff tear and impingement syndrome. His previous treatments were noted to include shoulder injections, chiropractic treatment, hot and cold wrap, a TENS unit, and physical therapy. The progress note dated 12/10/2013 revealed complaints of pain to the right shoulder and the surgery was being requested. The progress note dated 01/10/2014 revealed complaints of mid back and bilateral shoulders pain. The physical examination revealed a positive Obrien and cross arm test. There was tenderness along the rotator cuff and no weakness to resisted function noted. The progress note dated 01/22/2014 revealed complaints of right shoulder pain rated 4/10 to 5/10 and after treatment it was reduced to 2/10 to 3/10. The physical examination of the right shoulder noted range of motion with flexion was to 132/180 degrees and then became 158/180 degrees; extension was to 46/50 degrees and moved up to 50/50 degrees; abduction was 108/180 degrees and moved up to 130/180 degrees; right external rotation was 55/90 degrees and moved up to 72/90 degrees; and internal rotation was normal at 90 degrees. The muscle strength for shoulder flexion and abduction was 2/5 and moved up to 3/5. The dermatomal sensitivity was normal in the upper extremities bilaterally. The Request for Authorization form was not submitted within the medical records. The request was for right shoulder decompression, evaluation of distal clavicle excision and rotator cuff labrum and biceps, polar care times 21 days, and general anesthesia; the provider's rationale was not submitted within the medical records. The Request for Authorization form for preoperative clearance was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder, Decompression, Evaluation of Distal Clavicle Excision and Rotator Cuff Labrum and Biceps: Upheld

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

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

Decision rationale: The MTUS/ACOEM Guidelines state rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. Rotator cuff tears are frequently partial thickness or smaller full thickness tears. For partial thickness rotator cuff tears and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The preferred procedure is usually arthroscopic decompression, which involved debridement of inflamed tissue, burring of the anterior acromion, lysis, and sometimes, removal of the coracoacromial ligament, and possibly removal of the outer clavicle. Surgery is not indicated for patients with mild symptoms or those whose activities are not limited. Studies evaluating results of conservative treatment of full thickness rotator cuff tears have shown 82% to 86% success rate for patients presenting within 3 months of injury. The efficacy of arthroscopic decompression for full thickness tears depends on the size of the tear; 1 study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes of rotator cuff tears are much better in younger patients than in older patients who may be suffering from degenerative changes in the rotator cuff. The documentation provided indicated the MRI performed 12/30/2013 revealed a full thickness cuff tear; however, there were no tears to the labral, biceps, or acromioclavicular joint pathology noted. Therefore, the request is not medically necessary.

Pre-Op Clearance - H&P/CBC/CMP/EKG/Chest X-Rays: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Preoperative testing, general.

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

Polar Care x 21 Days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous-flow Cryotherapy.

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

General Anesthesia: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Regional Anesthesia.

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

Immobilizer: 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): 205-206.

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