

Case Number:	CM14-0049165		
Date Assigned:	06/25/2014	Date of Injury:	05/07/2005
Decision Date:	07/25/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	03/26/2014

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 Hand 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 72-year-old male who reported an injury on 6/7/05. The mechanism of injury was not submitted for review. The injured worker underwent an MRI on 2/25/14 that documented there was a large tear of the supraspinatus and infraspinatus and evidence of mild supraspinatus and moderate infraspinatus atrophy. The injured worker was evaluated on 3/4/14. It was documented that the injured worker had undergone distal clavical resection and open rotator cuff repair; however, he had persistent pain complaints that were described as increasing, causing an inability to raise the injured worker's arm and causing disrupted sleep patterns. It is noted that the injured worker was treated conservatively with several injections and a home exercise program. However, the injured worker continued to be limited in his ability to participate in activities of daily living. The injured worker's diagnoses included full thickness rotator cuff tear. A treatment recommendation was made for arthroscopic rotator cuff repair. The injured worker was evaluated on 3/20/14. Physical findings at that appointment included painful palpation at the subacromial bursa with restricted range of motion described as 90 degrees in flexion, 75 degrees in abduction, and 30 degrees in external rotation with 4/5 supraspinatus strength, and 5-/5 external rotator strength. It is noted that the injured worker had participated in at least six months of conservative treatment prior to the request for surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopic Rotary Cup Repair with Compression: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 561-563.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 210-211.

Decision rationale: The ACOEM recommends rotator cuff repair for patients who have significantly limited functionality, supported by an imaging study that has failed to respond to conservative treatment. The clinical documentation submitted for review indicates that the injured worker has significant pain complaints interfering with his ability to sleep and complete activities of daily living. The documentation included an MRI that supported a full thickness rotator cuff tear. Additionally, it is noted within the submitted documentation that the injured worker has failed to respond to several corticosteroid injections and six months of an intensive home exercise program. Therefore, surgical intervention would be indicated for this injured worker. As such, the request is medically necessary.

Polar Care Right Shoulder, Stable Sling Right 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): 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The California ACOEM/MTUS does not address continuous flow cryotherapy. The Official Disability Guidelines recommend up to seven days of continuous flow cryotherapy following shoulder surgery. However, the request as it is submitted does not clearly identify a treatment duration or whether the requested equipment is for rental or purchase. In the absence of this information, the appropriateness of the request itself cannot be determined. The ACOEM does support a short period of immobilization for acute shoulder pain. The clinical documentation supports that the injured worker is a surgical candidate which would be followed by acute pain related to the surgery. Therefore, a short course of immobilization would be indicated. However, as the request includes the Polar Care to the right shoulder, the appropriateness of the request in its entirety is not supported. As such, the request is not medically necessary.