

Case Number:	CM14-0063311		
Date Assigned:	07/11/2014	Date of Injury:	02/05/2014
Decision Date:	08/08/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/05/2014

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 Orthopaedic 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 50-year-old female nurse manager sustained an industrial injury on 2/5/13. Injury occurred when she was assisting a caregiver in moving a patient. Records indicate that a 5/22/13 right shoulder magnetic resonance imaging (MRI) showed inflammatory changes at the supraspinatus, possible partial thickness tearing, unable to rule-out a small full-thickness tear/perforation. A subacromial injection was documented on 9/3/13, noted as #2, with no response indicated. The patient underwent right wrist arthroscopic debridement and triangular fibrocartilage complex (TFCC) repair with excision of ganglion cyst on 2/3/14. The 3/3/14 orthopedic report cited right shoulder pain, increased with internal rotation or any overhead work. Shoulder pain was increased at night. Right shoulder exam documented increased pain with internal rotation and positive lift-off test, and positive provocative testing for rotator cuff tear. There were negative signs of impingement, bursitis or acromioclavicular joint arthritis. The treatment plan recommended arthroscopic evaluation, debridement and repair of rotator cuff. The patient remained symptomatic despite two steroid injections and a course of therapy for her shoulder. The 3/25/14 treating physician report cited constant grade 7/10 right shoulder pain. There was pain and tenderness right shoulder, and range of motion limited by pain. The patient finished her hand/wrist physical therapy and additional physical therapy for the wrist was recommended. The 4/22/14 utilization review denied the request for right shoulder surgery, as there was no documentation that the patient had failed guideline-recommended conservative treatment, or had activity limitations. The 5/1/14 treating physician reports cited constant grade 5/10 wrist and shoulder pain. Objective findings documented difficulty raising her arm above shoulder level, pain with range of motion, trapezius and lateral neck pain, and tenderness to palpation. The treatment plan indicated opioid medications were prescribed. The patient remained off work.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right Shoulder Arthroscopy, Subacromial Decompression and Rotator Cuff Repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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, Surgery for Rotator Cuff Repair, Surgery for Impingement Syndrome.

Decision rationale: The ACOEM guidelines state that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The Official Disability Guidelines provide specific indications for repair of partial thickness rotator cuff tears and impingement surgery that generally require 3 to 6 months of conservative treatment plus weak or absent abduction, positive impingement sign with a positive diagnostic injection test, and positive imaging evidence of impingement. Guideline criteria have not been met. There is a chart note indicating the presence of imaging evidence of a possible partial rotator cuff tear. There is no current documentation of a positive impingement sign or a diagnostic injection test. There is no indication of weakness or limitation in range of motion that failed to improve with physical therapy. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment directly to the shoulder had been tried and failed. Therefore, this request for right shoulder arthroscopy, subacromial decompression and rotator cuff repair is not medically necessary.

1 Airplane Splint: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

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

21 Day Rental of a Continuous Passive Motion Unit: 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 passive motion (CPM).

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

12 Sessions of Post Operative Physical Therapy: Upheld

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

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.