

Case Number:	CM14-0075149		
Date Assigned:	07/16/2014	Date of Injury:	03/10/2014
Decision Date:	11/04/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/22/2014

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 is a 55 years old female claimant with an industrial injury dated 03/10/14. MRI of the left shoulder dated 04/04/14 reveals a near full thickness tear distal supraspinatus tendon, mild to moderate acromioclavicular degenerative joint disease, and subacromial subdeltoid bursitis. Exam note 04/28/14 states that the patient returns with left shoulder pain. The patient rated the pain a 8-10/10. She describes the pain as sharp, achy, and constant. Upon physical examination there was tenderness to palpation at the anterolateral capsule and rotator cuff. The patient demonstrated a painful arc range of motion ranging from 90'-130' and weakness with isolater rotator cuff testing. The left shoulder demonstrated a normal flexion, extension, abduction, adduction, internal rotation, and external rotation. Motor strength was a 5/5 throughout, and there was positive signs of irritation during the impingement maneuvers. Sensation was normal, and there was no sign of sulcus. Diagnosis is noted as left shoulder impingement and treatment includes subacromial decompression with cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic subacromial decompression.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Surgery

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, acromioplasty

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care that is not present in the submitted clinical information from 4/28/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 4/28/14 does not demonstrate evidence satisfying the above criteria except for a painful arc of motion and weakness with abduction testing. Therefore, the request is not medically necessary.

Surgical assist by PA: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-operative clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/contnet.aspx?id=38289> Preoperative evaluation

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Left shoulder rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Indication for surgery-Rotator cuff repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Surgery for rotator cuff tear

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 4/28/14 do not demonstrate 4 months of failure of activity modification. The note from 4/28/14 does not demonstrate night pain or relief from anesthetic injection. Therefore, the request is not medically necessary.