

Case Number:	CM14-0076831		
Date Assigned:	07/18/2014	Date of Injury:	01/23/2014
Decision Date:	08/26/2014	UR Denial Date:	05/07/2014
Priority:	Standard	Application Received:	05/27/2014

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 47-year-old male sustained an industrial injury on 1/23/14, due to repetitive overhead activities with lifting. A corticosteroid injection to the right shoulder was provided on 3/13/14, there was no subsequent indication of response. The 4/10/14 right shoulder MRI impression documented supraspinatus and infraspinatus tendinosis without tear, mild acromioclavicular osteoarthritis with laterally downsloping acromion, and minimal subacromial-subdeltoid bursitis. The 4/24/14 treating physician report cited "grade 2-8/10 right shoulder pain with frequent bouts of sharp pain and a mild sense of swelling." Pain was reported with overhead activities, reaching behind and sleeping on the right shoulder and he had pain picking up objects off the ground. Physical therapy was in process. Right shoulder exam documented no tenderness over the acromioclavicular joint or the bicipital groove and the Neer's and Hawkin's tests were positive. The patient had full passive glenohumeral range of motion with grip strength of 5. Specialized stability testing demonstrated negative external rotation impingement. The MRI was reviewed and demonstrated an intact rotator cuff. The diagnosis was right shoulder subacromial bursitis. The treatment plan requested right shoulder arthroscopic debridement and decompression. The 5/7/14 utilization review denied the request for right shoulder arthroscopic debridement and decompression and associated requests based on an absence of imaging evidence of a surgical lesion and no documentation of response to the 3/13/14 injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic debridement/decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG, Indications for surgery - Acromioplasty.

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

Decision rationale: The ACOEM guidelines state that "surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months." Guideline criteria have not been met. The patient was 3-months status post injury at the time of this request. Physical therapy was still in process with no documentation that the patient had failed to improve or that further improvement was not anticipated. A cortisone injection was provided on 3/13/14 with no documentation of any response. Imaging findings did not demonstrate a rotator cuff tear instead imaging showed some mild acromioclavicular (AC) osteoarthritis with laterally downsloping acromion but there was no tenderness over the AC joint. Therefore, this request for right shoulder arthroscopic debridement/decompression is not medically necessary.

Pre-operative evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG, Indications for surgery - Acromioplasty.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

Pre-operative laboratory work-up: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG, Indications for surgery - Acromioplasty.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

Pre-operative EKG (electrocardiogram): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG, Indications for surgery - Acromioplasty.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

Post-operative physical therapy, twelve (12) visits: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG, Indications for surgery - Acromioplasty.

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.