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| Case Number: | CM14-0079764 | | |
| Date Assigned: | 07/18/2014 | Date of Injury: | 05/02/2007 |
| Decision Date: | 08/15/2014 | UR Denial Date: | 05/21/2014 |
| Priority: | Standard | Application Received: | 05/30/2014 |

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 59-year-old female production/assembly worker sustained an industrial injury on 5/2/07. Injury occurred while lifting heavy things overhead on the assembly line. The patient was deemed permanent and stationary on 4/14/10 with no interim treatment records available. The 11/4/13 orthopedic consult report cited progressively worsening left shoulder pain. The left shoulder exam documented subacromial pain, some acromioclavicular (AC) joint tenderness, and no gross weakness. The left shoulder range of motion testing demonstrated flexion 85 and abduction 70 degrees. X-rays showed no excessive degenerative changes. A subacromial injection was performed with improvement noted. The treatment plan opined the possible need for a subacromial decompression and suggested the need for an updated MRI. The 12/16/13 left shoulder MRI findings documented a Type 1 acromion and mild AC joint osteoarthritis. The 1/16/14 treating physician note indicated that the MRI showed a spur on the AC joint. She had had injections with some relief. The patient was a reasonable candidate for subacromial decompression and AC arthroplasty because of persistent pain and failure of conservative measures. The 5/7/14 treating physician note indicated that patient had continued significant shoulder pain. Authorization was requested for a subacromial decompression, AC arthroplasty, and possible limited open rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Subacromial Decompression, AC Arthroplasty and possible Limited Open Rotator Cuff Repair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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) Arthroplasty (shoulder), Surgery for rotator cuff repair, Surgery for impingement syndrome.

Decision rationale: The California MTUS does not provide specific recommendations for total shoulder replacement. The ACOEM guidelines for rotator cuff tears and impingement syndrome state that surgery is reserved for cases failing conservative treatment, including injections, for 3 months. The ODG recommend arthroplasty for selected patients. Surgical indications include glenohumeral or acromioclavicular (AC) joint osteoarthritis with severe pain preventing a good night's sleep or functional disability that interferes with activities of daily living or work, positive radiographic findings of shoulder joint degeneration, and failure of at least 6 months of conservative treatment. The Guideline criteria have not been met. There is no detailed documentation that recent comprehensive guideline-recommended conservative treatment had been tried for at least 6 months and had failed. There are no current clinical exam findings to establish the medical necessity of surgical intervention. There are no current pain or functional assessments. Imaging findings documented mild AC joint osteoarthrosis. Therefore, this request for left shoulder subacromial decompression, AC arthroplasty and possible limited open rotator cuff repair is not medically necessary.

Post-Operative Physical Therapy, Left Shoulder 3x4: 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.