

Case Number:	CM13-0013709		
Date Assigned:	03/10/2014	Date of Injury:	02/17/2011
Decision Date:	05/08/2015	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/19/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 53-year-old male who reported injury on 11/17/2011. The mechanism of injury was the injured worker was driving a forklift in the cooler and his lift was struck by another employee's lift that was loaded with product. The injured worker underwent a right shoulder arthroscopy with extensive intra-articular debridement and subacromial bursectomy on 06/16/2011. The documentation of 01/22/2013 revealed the injured worker had an MRI arthrogram of the right shoulder on 12/12/2012, which revealed extensive labral tearing involving the superior labrum and the posterior labrum 7 to 12 o'clock. There was an absent anterior superior labrum likely secondary to developmental variant of Buford complex. There was a moderate glenohumeral joint arthrosis and mild articular sided fraying of the supraspinatus tendon without tear. The examination of the shoulder revealed restricted range of motion with flexion, abduction of 140 degrees, external rotation of 60 degrees, and internal rotation of 45 degrees. The diagnosis included a labral tear of the right shoulder with failed arthroscopic surgery. The treatment plan included surgical intervention including a right shoulder arthroscopic surgery with labral repair, a hot and cold compression unit, CPM unit, and Pro Sling with abduction pillow. The injured worker would need an internal medicine clearance and was noted to have not reached maximum medical improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with Subacromial Decompression with Posterior Labral Repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Surgery for SLAP Lesions.

Decision rationale: The American College of Occupational and Environmental Medicine indicates a surgical consultation may be appropriate for injured workers who have a failure to increase range of motion and strength of musculature in the shoulder after exercise programs and who have clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. For injured workers with a partial thickness or small full thickness tear, impingement surgery is reserved for cases failing conservative care therapy for 3 months and who have imaging evidence of rotator cuff deficit. For surgery for impingement syndrome, there should be documentation of conservative care including cortisone injections for 3 to 6 months before considering surgery. They do not, however, address labral tears. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that the criteria for surgery for a SLAP lesion include surgical repair after 3 months of conservative therapy, and there should be documentation of a type II or type IV lesion. The type IV lesion involves more than 50% of the tendon, there is a vertical tear, bucket handle tear of the superior labrum extending into the biceps, or an intrasubstance tear. The history and physical examination and imaging should indicate the pathology. The clinical documentation submitted for review indicated the injured worker had an extensive labral tear involving the superior labrum and posterior labrum in the 7 to 12 o'clock positions. The injured worker had objective findings upon physical examination. However, there was a lack of documentation indicating the injured worker had undergone prior conservative care. Given the above, the request for Right Shoulder Arthroscopy with Subacromial Decompression with Posterior Labral Repair is not medically necessary.

Associated Surgical Service: Assistant Surgeon: Upheld

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

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

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

Cold Therapy Unit: Upheld

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

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

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

Associated Surgical Service: Arm Sling: Upheld

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

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

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

Post Operative Physical Therapy (12-visits): Upheld

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

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

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