

Case Number:	CM14-0183599		
Date Assigned:	11/10/2014	Date of Injury:	10/08/2013
Decision Date:	03/17/2015	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	11/04/2014

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. 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, Tennessee, South Carolina
 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:

According to the records made available for review, this is a 58-year-old female with a 10/8/13 date of injury. At the time (10/8/14) of the Decision for labral anterior-posterior repair, biceps tenodesis, excision clavicle; surgical assistant; pre-operative laboratories; medical clearance; electrocardiogram (EKG); and right shoulder sub-acromial decompression, rotator cuff tears repair, superior, there is documentation of subjective (daily pain in the neck and right shoulder, pain is worse with overhead reaching and at night) and objective (tenderness over the anterior aspect of the right shoulder, decreased range of motion, impingement and abduction sign were positive) findings, current diagnoses (right rotator cuff tear and right acromioclavicular joint arthritis), and treatment to date (medication and physical therapy). There is no documentation of objective clinical findings (temporary relief of pain with anesthetic injection (diagnostic injection test)) and imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgical assistant: 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), Low Back Chapter

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.

Pre-operative laboratories: 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), Low Back Chapter

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.

Medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The National Guidelines Clearinghouse, Perioperative Protocol, Health Care Protocol, page 124

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.

Electrocardiogram (EKG): 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), Low Back Chapter

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.

Right shoulder sub-acromial decompression, rotator cuff tears repair, superior labral anterior-posterior repair, biceps tenodesis, excision clavical: Upheld

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

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

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of right rotator cuff tear and right acromioclavicular joint arthritis. In addition, there is documentation of conservative care for 3 to 6 months, subjective clinical findings (pain and pain at night), and objective clinical findings (tenderness over the anterior aspect of the right shoulder, decreased range of motion, impingement and abduction sign were positive). However, there is no documentation of objective clinical findings (temporary relief of pain with anesthetic injection (diagnostic injection test)) and imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff. Therefore, based on guidelines and a review of the evidence, the request for right shoulder subacromial decompression, rotator cuff tears repair, superior is not medically necessary.