

Case Number:	CM14-0185120		
Date Assigned:	11/13/2014	Date of Injury:	02/27/2013
Decision Date:	01/31/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/06/2014

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:

According to the records made available for review, this is a 55-year-old male with a 2/27/13 date of injury. At the time (10/22/14) of request for authorization for Rotator cuff repair, post operative therapy (x6), and cold therapy unit dispensed in office (pad, cooler), there is documentation of subjective (bilateral shoulder pain) and objective (positive Hawkin's test and tenderness over the greater tuberosity) findings, imaging findings (reported MRI of the left shoulder (3/13/13) revealed intact rotator cuff without any partial tears and MRI of the right shoulder (12/13/13) revealed rotator cuff intact without a partial tear; reports not available for review), current diagnoses (bilateral impingement syndrome), and treatment to date (medications, steroid injections, and physical therapy). Regarding Rotator cuff repair, there is no documentation of additional subjective findings (pain at night); and an imaging report with findings (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:

Rotator Cuff Repair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (<http://www.odgtwc.com/odgtwc/shoulder.htm#Surgeryforrotatorcuffrepair>)

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) Shoulder Chapter, Subacromial Decompression and Manipulation Under Anesthesia

Decision rationale: California 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 rotator cuff repair. Official Disability Guidelines (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 rotator cuff repair. Within the medical information available for review, there is documentation of a diagnosis of bilateral impingement syndrome. In addition there is documentation of objective (tenderness over the greater tuberosity and positive Hawkin's test) findings. Furthermore, there is documentation of failure of conservative therapy treatments. However, despite documentation of subjective (bilateral shoulder pain) findings, there is no documentation of additional subjective findings (pain at night). In addition, given documentation of medical report's reported imaging findings (MRI of bilateral shoulder identifying intact rotator cuff without a partial tear), there is no documentation of an imaging report with findings (evidence of deficit in rotator cuff). Therefore, based on guidelines and a review of the evidence, the request for Rotator cuff repair is not medically necessary.

Post Operative Therapy (X6): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment Protocols 5th Edition

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 Dispensed In Office (Pad, Cooler): Upheld

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

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.