

Case Number:	CM14-0190146		
Date Assigned:	11/21/2014	Date of Injury:	04/17/2008
Decision Date:	01/09/2015	UR Denial Date:	11/01/2014
Priority:	Standard	Application Received:	11/14/2014

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:

43 year old male claimant with an industrial injury dated 04/17/08. The patient is status post a right shoulder arthroscopy, debridement of superior labrum and synovium, biceps tenotomy, revision of the rotator cuff repair, and subacromial decompression dated 05/16/14. MR arthrogram of the right shoulder dated 10/16/14 reveals interval irregularity of the supraspinatus tendon with focal tear at the distal attachment, and postoperative changes of the glenoid with loss of the labral tissue anteriorly as well as at the biceps labral complex with contrast undercutting the mid to posterior aspect of the superior labrum with tear. Exam note 10/23/14 states the patient returns with shoulder pain. The patient explains that physical therapy has provided no pain relief, and it reinjured the right shoulder in September. Upon physical exam there was evidence of swelling surrounding the right shoulder, and crepitation in the subacromial area. There was also subacromial and acromial clavicular tenderness, subacromial bursa tenderness, and greater tuberosity tenderness. The patient had 140' of passive right shoulder flexion, 160' of active right shoulder flexion, 120' of right shoulder abduction with pain, and 20' of external rotation. The patient completed a positive Neer's impingement test, and had normal upper extremity sensation. Diagnosis is noted as a complete rotator cuff rupture and shoulder pain. Treatment includes a right shoulder surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right Shoulder Arthroscopy with debridement, revision of right rotator cuff repair, possible open repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disabilities Guidelines, Acromioplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for Rotator Cuff Tear

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 10/23/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 10/23/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is for non-certification for the requested procedure.

12 Physical Therapy Sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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.