MAXIMUS Federal Services

Case Number:	CM14-0195878		
Date Assigned:	12/03/2014	Date of Injury:	10/11/2011
Decision Date:	01/28/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/21/2014

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 Minnesota. 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:

The injured worker is a 43-year-old male with a date of injury of 10/11/2011 pertaining to the left shoulder. His initial injury was a rotator cuff tear that was repaired in 2011 but he continued to complain of pain afterwards. He underwent an MR arthrogram which showed a re-tear. He underwent a redo rotator cuff repair on November 6, 2013. The operative report indicated a difficult arthroscopic rotator cuff repair. He continued to experience pain which got worse in May 2014. An MR arthrogram of the left shoulder performed on 5/29/2014 revealed a suture anchor in the greater tuberosity suggesting a prior rotator cuff repair. There was a small focus of abnormal signal in the anterior margin of the humerus at the lower aspect of the bicipital groove related to prior biceps tendon surgery. There was widened appearance of the acromioclavicular joint due to prior surgery there was mild heterogenous signal within the supraspinatus tendon with a full-thickness tendon perforation at the anterior distal margin without significant tendon retraction. The majority of the tendon root appeared intact. There was a small gadolinium collection in the tendon substance and subacromial subdeltoid bursa. The infraspinatus tendon and teres minor tendon were intact. The subscapularis was intact. No rotator cuff muscle atrophy was noted. The long head of biceps was not visualized at the superior aspect of the bicipital groove. There was a small residual portion of biceps tendon at the biceps anchor. The glenoid labrum was intact. In light of continuing pain the provider has requested additional surgery although the MR arthrogram only showed a small perforation in the supraspinatus tendon and no muscle atrophy. The rest of the cuff was intact. The labrum was also intact. Based on the above utilization review noncertified the requested surgery and the ancillary services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional arthroscopic evaluation, arthroscopic rotator cuff repair, coracoid decompression, subacromial revision decompression and debridement as indicated, left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: California MTUS guidelines indicate rotator cuff repair is indicated for significant tears that impair activities by causing weakness of the arm elevation or rotation. The MR arthrogram has revealed a perforation in the supraspinatous tendon without retraction and without any associated muscle atrophy. Most of the rotator cuff is intact. The injured worker has had 2 prior repairs and his symptoms have never completely cleared. The MR arthrogram does not show any evidence of impingement to justify a repeat subacromial decompression. There is no evidence of subcoracoid impingement to warrant a decompression. Based upon the guidelines the medical necessity of a repeat arthroscopic decompression or rotator cuff repair is not substantiated.

Associated surgical service: Pre-operative medical clearance: 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: Supervised post-operative rehabilitative therapy; twelve (12) sessions (3 times a week for 4 weeks): 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: Home continuous passive motion (CPM) device, for an initial period of 45 days: 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: Surgi Stim unit, for an initial period of 90 days: 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: Coolcare 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.