

Case Number:	CM14-0196021		
Date Assigned:	12/04/2014	Date of Injury:	07/30/2012
Decision Date:	01/27/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	11/24/2014

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:

This 54 year old female was injured on 7/30/12 from a fall she sustained as she was exiting her vehicle resulting in injuries to her left upper extremity/ shoulder, chest wall, right elbow and cervical region. She complained of increasing, constant pain in the left shoulder with radiation to the upper arm that is aggravated with repetitive movement; intermittent right elbow pain and left cervicobrachial region into the base of the cervical spine. Her chest wall symptoms did resolve. She had an MRI of the left shoulder which revealed a rotator cuff tear and failed physical therapy. After conservative measures failed to satisfactorily alleviate left shoulder symptoms she underwent a rotator cuff repair on 2/4/14. The operative report is not available. After surgery (3/2014) the left shoulder pain increased. On physical exam there was spasm and guarding at the base of the cervical spine extending to the left cervicobrachial region. She also exhibited normal range of motion of the left shoulder but there was guarding secondary to pain. Psychological profile revealed depression and she was recommended to a mental health professional. Her diagnoses include internal derangement of the left shoulder, status post arthroscopic shoulder surgery (10/2014); chronic cervical strain and right elbow contusion; Impingement syndrome and lateral epicondylitis of the right shoulder. There was documentation of physical therapy from 5/12/14/to 5/15/14 that demonstrated improvement with active range of motion but continued to be limited by pain and weakness with all motions. An MRI of the cervical spine dated 10/9/14 revealed moderate C4-5 and C5-6 cervical spondylosis and moderate neural foramin stenosis at C6-7 with no impingement on the spinal cord or nerve roots. MRI of the right shoulder dated 10/1/14 demonstrates acromioclavicular joint arthrosis with mass effect on the superspinous tendon and partial thickness rotator cuff tear. MRI (10/1/14) left shoulder demonstrates a small tear within the anterior fibers of the infraspinatus tendon. Her current medications include Vicodin, Voltaren, Ultram and Motrin. Laboratory tests were done on 9/8/14 to determine the

current level of prescription medications and were consistent with medications prescribed. Acupuncture was suggested but there is no documentation that this was started. There was no documentation of functional improvement. She is temporarily totally disabled and is unable to return to work at this time. On 11/13/14 Utilization Review non-certified the requests for rotator cuff repair, possible SLAP repair, possible open biceps tenodesis, excision of distal clavicle; pre-operative laboratory studies; pre-operative electrocardiogram; surgical assistant; left shoulder arthroscopy, subacromial decompression based on no official report of imaging studies and no clear documentation of failure of conservative care with respect to medication usage, physical therapy, injection therapy and active home exercise program. This information is crucial in determining the failure of care. The referenced guidelines were ACOEM, Shoulder Complaints and ODG/ Shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Rotator cuff repair, possible SLAP repair, possible open biceps tenodesis: Upheld

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

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

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 10/20/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 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.

Excision distal clavicle: 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.

Pre-operative labs; CBC, Metabolic chem: 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.

Pre-op labs: EKG: 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.

Surgical assistant: 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.

LEFT shoulder arthroscopy, subacromial decompression: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty

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. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 10/20/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic

injection. In this case the exam note from 10/20/14 does not demonstrate evidence satisfying the above criteria. Therefore the determination is for non-certification.