

Case Number:	CM14-0198185		
Date Assigned:	12/08/2014	Date of Injury:	07/16/2012
Decision Date:	01/21/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/25/2014

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 36-year-old male with a 7/16/12 date of injury, and status post left shoulder arthroscopy, subacromial decompression, rotator cuff repair, and labrum debridement 1/8/13. At the time (11/3/14) of request for authorization for left shoulder arthroscopy RTC repair, SLAP debridement, subacromial decompression (SAD), Assistant Surgeon, preoperative clearance (history and physical, CBC, and EKG), postoperative physical therapy 2 times a week for 6 weeks, cold therapy, and sling, there is documentation of subjective (left shoulder pain) and objective (active range of motion 160, pain between 160 and 170 degrees, external rotation 30 degrees, rotator cuff strength 4+/5) findings, imaging findings (reported shoulder MRI (12/12/13) findings include partial tearing of the supraspinatus tendon, and a type II acromion; report not available for review), current diagnoses (left shoulder rotator cuff tear), and treatment to date (physical therapy and medications). There is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; objective clinical findings: weak or absent abduction; 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); and an imaging report.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy RTC Repair: 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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Subacromial Decompression

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 diagnosis of left shoulder rotator cuff tear. In addition, there is documentation of conservative care for 3 to 6 months. However, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and 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). In addition, despite the medical reports' reported imaging findings (shoulder MRI identifying partial tearing of the supraspinatus tendon, and a type II acromion); there is no documentation of an imaging report. Therefore, based on guidelines and a review of the evidence, the request for Left Shoulder Arthroscopy RTC Repair is not medically necessary.

SLAP Debridement: Upheld

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

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

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 diagnosis of left shoulder rotator cuff tear. In addition, there is documentation of conservative care for 3 to 6 months. However, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and 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). In addition, despite the medical reports' reported imaging findings (shoulder MRI identifying partial tearing of the supraspinatus tendon, and a type II acromion); there is no documentation of an imaging report. Therefore, based on guidelines and a review of the evidence, the request for SLAP debridement is not medically necessary.

Subacromial Decompression (SAD): Upheld

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

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

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 diagnosis of left shoulder rotator cuff tear. In addition, there is documentation of conservative care for 3 to 6 months. However, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and 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). In addition, despite the medical reports' reported imaging findings (shoulder MRI identifying partial tearing of the supraspinatus tendon, and a type II acromion), there is no

documentation of an imaging report. Therefore, based on guidelines and a review of the evidence, the request for Subacromial Decompression (SAD) is not medically necessary.

Assistant Surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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.

Preoperative Clearance (History and Physical, CBC, and EKG): Upheld

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

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.

Postoperative Physical Therapy 2 Times A Week for 6 Weeks: 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.

Cold Therapy: 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)

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.

Sling: 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)

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.