

Case Number:	CM14-0099180		
Date Assigned:	09/16/2014	Date of Injury:	02/26/2008
Decision Date:	01/05/2015	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	06/27/2014

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 56-year-old female with a 2/26/08 date of injury. At the time (6/18/14) of request for authorization for surgery video athroscopy with subacromial decompression, debridement versus rotator cuff repair, possible debridement glenoid labrum and possible distal clavicle arthroplasty, of the right shoulder; medical clearance pre-operative including history and physical; labs pre-op CBC,PT,PTT, Lytes, BUN, UA Chem-7; pre-op chest X-ray; EKG; post-op cold therapy unit rental for seven to ten days qty:10; post-op pain pump catheter for two- day rental#2; post-op ultra sling #1; and post-op physical therapy for 12 sessions, there is documentation of subjective (right shoulder pain) and objective (right shoulder abduction of 90 degrees, moderate to severe pain with internal as well as external rotation, right arm muscle strength of 4/5, positive impingement sign as well as positive Neer's sign over right shoulder, tenderness over right biceps groove as well as rotator cuff region) findings, imaging findings (MRI right shoulder (4/2/14) report revealed cuff tendinitis with swelling and edema developing interstitial tear of the supraspinatus tendon, calcific tendinitis/bursitis, and glenohumeral capsulitis), current diagnoses (right shoulder partial rotator cuff tear and right shoulder impingement syndrome), and treatment to date (medications, cortisone injection, and physical therapy). Regarding surgery video athroscopy with subacromial decompression, debridement versus rotator cuff repair, possible debridement glenoid labrum and possible distal clavicle arthroplasty, of the right shoulder, there is no documentation of additional subjective clinical finding (pain at night).

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery video arthroscopy with subacromial decompression, debridement versus rotator cuff repair, possible debridement glenoid labrum and possible distal clavicle arthroplasty, of the right 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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines

Decision rationale: The California MTUS Guidelines 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. The Official Disability Guidelines 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 diagnoses of right shoulder partial rotator cuff tear and right shoulder impingement syndrome. In addition, there is documentation of subjective (pain with active arc motion 90 to 130 degrees) and objective (failure to increase range of motion and strength of the musculature around the shoulder, weak abduction, tenderness over rotator cuff, and positive impingement sign) clinical findings; imaging clinical findings showing positive evidence of deficit in rotator cuff; and failure of conservative treatment (cortisone injections, medications, and physical therapy). However, despite documentation of subjective (pain), there is no (clear) documentation of additional subjective clinical finding (pain at night). Therefore, based on guidelines and a review of the evidence, the request for surgery video athroscopy with subacromial decompression, debridement versus rotaor cuff repair, possible debridement glenoid labrum and possible distal clavicle arthroplasty, of the right shoulder is not medically necessary.

Per-Operative Medical Clearance including history and physical: 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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for medical clearance pre-operative including history and physical is not medically necessary.

Per-Operative Labs: CBC, PT, PTT, Lytes, BUN, UA Chem-7: 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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for labs pre-op CBC,PT,PTT, Lytes, BUN, UA Chem-7 is not medically necessary.

Per-Operative Chest X-Ray: 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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for pre-op chest X-ray is not medically necessary.

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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for EKG is not medically necessary.

Post-Operative Cold Therapy Unit rental for seven to ten 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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for post-op cold therapy unit rental for seven to ten days qty:10 is not medically necessary.

Post-Operative Pain Pump Catheter for two-day rental: 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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for post-op pain pump catheter for two- day rental #2 is not medically necessary.

Post-Operative Ultra Sling: 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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for post-op ultra sling #1 is not medically necessary.

Post-Operative Physical Therapy (12 sessions): 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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for post-op physical therapy for 12 sessions is not medically necessary.