

Case Number:	CM15-0140639		
Date Assigned:	07/30/2015	Date of Injury:	08/27/2013
Decision Date:	09/02/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Minnesota, Florida

Certification(s)/Specialty: Orthopedic Surgery

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 65 year old male who sustained an industrial injury on 8-27-2013. Mechanism of injury is not documented. He reports neck pain an 8-9 out of 10, left shoulder pain an 8 out of 10, right shoulder pain a 7 out of 10, left elbow pain a 7 out of 10, and left hand wrist pain a 6-7 out of 10. Diagnoses included chronic neck strain with underlying mild degenerative disc disease and mild disc protrusion, status post left shoulder rotator cuff repair with residual significant decreased painful motion and underlying mild degenerative joint disease of AC joint, right shoulder strain with underlying mild degenerative joint disease improved, left elbow lateral epicondylitis, and left wrist strain. Treatment has included medical imaging, medications, surgery, and physical therapy. Cervical spine was mild decreased painful range of motion. There was tenderness to palpation. Right shoulder revealed mildly decreased painful motion with tenderness to palpation. Left shoulder was significantly decreased active range of motion with tenderness to palpation at the AC joint. The left elbow was tender to palpation. The left wrist was tender to palpation. The treatment plan included follow up, left shoulder rotator cuff repair with incision of the distal clavicle, and pain management consultation. The treatment request included a left shoulder rotator cuff repair with excision of distal clavicle.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder rotator cuff repair with excision of distal clavicle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, and 213. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Partial claviclectomy.

Decision rationale: The injured worker is a 65-year-old male with a date of injury of 8/27/2013. He underwent arthroscopic rotator cuff repair, biceps tenodesis and acromioclavicular joint arthroplasty with extensive debridement and subacromial decompression of the left shoulder on 2/21/2014. Postoperatively he received extensive physical therapy. The MRI scan of the left shoulder was repeated on 4/8/2015 because of continuing severe pain. The findings included evidence of prior rotator cuff repair with suture anchors within the greater tuberosity. There was widening of the acromioclavicular joint which measured 1.3 cm. The undersurface of the acromion was flat with no anterolateral down sloping. Severe tendinitis of the supraspinatus and infraspinatus tendons with a partial thickness tear but no full-thickness tears was documented. The progress notes of 5/7/2015 do not document range of motion or a detailed examination of the shoulder. Decreased range of motion and tenderness to palpation in the acromioclavicular joint was documented. Furthermore, the injured worker was complaining of pain in multiple body parts including neck pain 8-9/10, left shoulder pain to shoulder blade 8/10 and occasional right shoulder pain 7/10, intermittent left elbow pain 7/10 and left hand/wrist pain 6-7/10. Authorization was requested for a left shoulder rotator cuff repair with excision of the distal clavicle, Utilization review non-certified the request citing California MTUS and ODG guidelines. With regard to the request for a left shoulder rotator cuff repair, according to California MTUS guidelines a rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. Partial-thickness rotator cuff tears and small full-thickness rotator cuff tears are treated with 3-6 months of an exercise rehabilitation program with corticosteroid injections and physical therapy. The preferred procedure upon failure of non-operative treatment is subacromial decompression. However, in this case the MRI scan shows that subacromial decompression has been performed and the undersurface of the acromion is flat with no bone spurs. As such a repeat subacromial decompression is not necessary. There is no full-thickness rotator cuff tear that warrants surgical intervention. In light of the foregoing, the California MTUS guidelines do not support the request for a rotator cuff repair and the medical necessity of the request has not been substantiated. With respect to the partial claviclectomy, the MRI scan shows that the injured worker is status post a partial claviclectomy with 1.3 cm of space and no osteophytes. California MTUS guidelines do not include the criteria for a partial claviclectomy. ODG guidelines for partial claviclectomy necessitate imaging evidence of severe degenerative joint disease of the acromioclavicular joint in addition to failed conservative care for at least 6 weeks. The information submitted does not support the need for a partial claviclectomy and as such, the medical necessity of the request has not been substantiated.