

Case Number:	CM15-0169735		
Date Assigned:	09/16/2015	Date of Injury:	02/04/2015
Decision Date:	10/15/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	08/28/2015

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: California, Oregon, Washington
 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 41 year old male who sustained an industrial injury on 02-04-2015. According to a progress report dated 06-26-2015, the injured worker had injured his right shoulder. Treatment to date has included medications and physical therapy. "His symptoms did not improve." The injured worker reported nocturnal symptoms and weakness. Physical examination demonstrated full range of motion of the right shoulder and weakness with passive abduction and passive impingement. The injured worker was unable to do activities of daily living comfortably especially with overhead use. He wanted to have surgery performed on his shoulder. The treatment plan included surgery request. An MRI of the right shoulder performed on 04-20-2015 demonstrated rotator cuff impingement syndrome, type II acromion, downward sloping of the lateral aspect of the distal acromion. Also noted was rotator cuff tendinosis with complete tear supraspinatus tendon and anterior aspect infraspinatus tendon, severe atrophy supraspinatus muscle, minimal subcortical cyst formation at the posterior lateral aspect of the humeral head superiorly and fluid in the subacromial subdeltoid bursa. An authorization request dated 07-17-2015 was submitted for review. The requested services included right arthroscopy, distal clavicle resection, subacromial decompression, RCT repair, slap repair, possible OPEN, sling x 2 weeks, Vicodin, ES, physical therapy and surgical assistant. Diagnosis was rotator cuff, SLAP tears shoulder. On 07-24-2015, Utilization Review modified the request for right arthroscopy, distal clavicle resection, subacromial decompression, RCT repair, slap repair, possible open and authorized the request for sling x 2 weeks, Vicodin, physical therapy and surgical assistant.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right arthroscopy, distal clavicle resection, subacromial decompression, RCT repair, slap repair, possible OPEN: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2015, Shoulder (Acute and Chronic): Surgery for impingement syndrome, Surgery for rotator cuff repair and Surgery for SLAP lesions.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Partial Claviclectomy & acromioplasty surgery & labral tear surgery.

Decision rationale: Based upon the CA MTUS Shoulder Chapter. Pgs 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case, the exam note from 6/26/15 and the imaging findings from 4/20/15 do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore, the determination is for non-certification. 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 6/26/15. 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 6/26/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is for non-certification. 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. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. In this case there is insufficient evidence to warrant labral repair secondary to lack of physical examination findings, lack of documentation of conservative care or characterization of the type of labral tear. Therefore, determination is for non-certification.