

Case Number:	CM15-0021587		
Date Assigned:	02/11/2015	Date of Injury:	10/09/2014
Decision Date:	04/06/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/04/2015

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

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 56-year-old male who reported an injury on 10/09/2014. The mechanism of injury was noted to be a fall. The injured worker's diagnoses included rotator cuff syndrome of the shoulder and right shoulder rotator cuff tear with possible labral tear. There was a Request for Authorization submitted for review dated 12/16/2014. The documentation of 12/12/2014 revealed the injured worker had conservative care and exercises. The injured worker had ongoing activity limiting pain and weakness which was worse with overhead activity. The injured worker was noted to undergo x-rays which revealed no clear fracture. The objective findings revealed the injured worker had decreased range of motion of the right shoulder. The injured worker had mild diffuse tenderness. There was no swelling. The Popeye's sign was absent. The injured worker's strength on external rotation was 3/5 with pain in the supraspinatus, external rotation, and abduction. The Neer's and Hawkins tests were positive. The crank test was positive. X-rays were performed and the injured worker had a type 2 acromion. There was no fracture or dislocation. The recommendation was made for a right shoulder arthroscopy with rotator cuff repair, subacromial decompression, and possible labral repair. The injured worker underwent an MRI of the right shoulder on 12/05/2014 which revealed moderate to severe supraspinatus tendinosis with interstitial tearing and bursal surface fraying. There was mild adjustment subacromial/subdeltoid bursitis. There was a high grade partial thickness bursal surfaced tearing of the infraspinatus tendon with strain of the infraspinatus myotendinous junction. There was moderate subscapularis tendinosis with thin linear interstitial tearing. There was moderate tendinosis of the intra-articular long head of the biceps tendon with medial

subluxation into the subscapularis interstitial tear. There was degeneration of the entire glenoid labrum. There was mild partial thickness cartilage loss in the central aspect of the glenoid. There was moderate to severe acromioclavicular joint arthrosis. There was a subacute sprain of the inferior glenohumeral ligament.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, RTC repair and possible SLAP repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Surgery for SLAP lesions.

Decision rationale: The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for an injured worker who has activity limitations for more than 4 months, red flag conditions, failure to increase range of motion and strength of musculature around the shoulder even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Additionally, the guidelines indicate for a partial thickness rotator cuff tear presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The guidelines do not, however, address SLAP lesions. As such, secondary guidelines were sought. The Official Disability Guidelines indicate the criteria for surgery for a SLAP lesion include the injured worker should be under the age of 50 and there should be documentation of 3 months of conservative treatment. A type 2 and type 4 lesion is recommended for surgical intervention. The clinical documentation submitted for review indicated the injured worker had trialed conservative care. However, the injury was in 10/2014 and the documentation was in 12/2014. There was a lack of documentation of an exhaustion of conservative care. The decision to perform a SLAP repair would be decided intraoperatively. The injured worker had objective findings upon physical examination and MRI to support the necessity for surgical intervention. However, given the lack of documentation of specific conservative care and the duration of care of 3 months or greater, the request for a right shoulder arthroscopy, RTC repair, and possible SLAP repair is not medically necessary.

Associated surgical service: Cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Continuous Flow Cryotherapy.

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.

Post-op Smartsling for right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

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.

Associated surgical service: Physical therapy 2 x 10 for right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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.