

Case Number:	CM15-0055550		
Date Assigned:	03/30/2015	Date of Injury:	05/28/1997
Decision Date:	05/14/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	03/23/2015

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 64-year-old male who reported injury on 05/28/1997. The mechanism of injury was not provided. The diagnoses included rotator cuff sprain/strain. There was a request for authorization submitted for review dated 03/03/2015. The documentation of 12/17/2014 revealed the injured worker had right shoulder pain. The physical examination revealed tenderness to palpation laterally over the deltoid with an arthroscopy incision. The injured worker had marked limitation of motion and marked limitation in strength. The injured worker had a positive Neer and Hawkins test. The examination of the left upper extremity revealed tenderness to palpation over the lateral aspect of the deltoid with marked limitation of range of motion. All muscles were 5/5 with the exception of the supraspinatus which was 4/5 and external rotation was 4/5. The injured worker had an MRI of the right shoulder on 12/06/2014 which the physician documented revealed a recurrent full thickness of the repaired supraspinatus tendon and moderate severe glenohumeral arthritis. The diagnoses included rotator cuff tear, impingement syndrome shoulder, and osteoarthritis glenohumeral joint. The treatment plan included a surgical arthroscopic right shoulder rotator cuff repair, extensive debridement, revision subacromial decompression and large joint injection for postoperative pain control. Concurrently, the request was made for a sling with abduction pillow, cold therapy for 5 days, and postoperative physical therapy as well as a refill of Tylenol No. 4. The documentation of 02/25/2015 revealed the injured worker's physical examination remained the same with regard to the right shoulder. The treatment plan included awaiting authorization for an MRI of the right shoulder. The official MRI for the right shoulder dated 12/06/2014 revealed there was a recurrent

full thickness tearing of the repaired supraspinatus tendon 2.6 cm wide x 2.2 cm AP with scarring attenuation of partial tearing of the infraspinatus tendon anterior fibers. There was mild fatty atrophy of the supraspinatus and infraspinatus muscles. There was circumferential degenerative appearance of the labrum and there was moderate to severe glenohumeral joint arthrosis with regions of grade 4 cartilage loss and subchondral bone marrow edema. There was a superior migration of the humeral head within the narrowed subacromial space. The examination also revealed post subacromial decompression and distal clavicular excision changes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op physical therapy 2 x wk x 6 wks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

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: Polar care x 5 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

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: Ultra sling, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

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.

Right Shoulder Rotator Cuff Repair with Subacromial Decompression and Extensive Debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210 and 211.

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have a failure to increase range of motion and strength of musculature in the shoulder after exercise programs and who have clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. For injured workers with a partial thickness or small full thickness tear, impingement surgery is reserved for cases failing conservative care therapy for 3 months and who have imaging evidence of rotator cuff deficit. For surgery for impingement syndrome, there should be documentation of conservative care including cortisone injections for 3 to 6 months before considering surgery. The MRI revealed evidence of a full thickness tear. The injured worker had positive findings regarding impingement. The documentation indicated the injured worker had marked limitation in range of motion and mild limitation of strength. There was a lack of documentation of objective findings regarding strength and range of motion. While conservative care would not be necessary to support the surgical intervention, objective documentation related to range of motion and strength would be medically necessary to support the surgical intervention. Given the above, the request for Right shoulder rotator cuff repair with subacromial decompression and extensive debridement is not medically necessary.

Preoperative clearance with [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

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.