

Case Number:	CM15-0068787		
Date Assigned:	04/16/2015	Date of Injury:	08/14/2014
Decision Date:	07/07/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/10/2015

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: Illinois, California, Texas
 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 30-year-old male who sustained an industrial injury on 8/14/14. Injury occurred when he fell from a roof approximately 12 feet, hitting his head, right shoulder and right knee. He sustained a comminuted mid clavicle fracture. The 1/7/15 treating physician report cited right acromioclavicular (AC) joint localized pain. He had not returned to work. Physical exam documented unrestricted right shoulder range of motion, with moderate AC joint tenderness. There was no tenderness over the rotator cuff. Shoulder impingement tests were negative. There was no pain with resisted forward flexion with shoulder in full abduction and external rotation. Conservative treatment options were discussed and MRI was planned. The 1/21/15 right shoulder MRI impression documented 7 mm focus of low signal in the supraspinatus tendon, which may represent a focus of hydroxyapatite deposition disease. There was minimal articular sided tearing of the anterior fibers of the supraspinatus tendon. There was infraspinatus and subscapularis tendinosis with mild irregularity of the superior labrum. There was minimal acromioclavicular (AC) osteoarthritis. The 1/21/15 lumbar spine and right knee MRI studies were reported as normal. The 2/4/15/ treating physician report cited complaints of right AC joint localized discomfort. He had findings of calcific tendinitis, which could be managed non-operatively or with surgery. The treating physician opined there were significant psychosocial barriers to recovery and return to work. The diagnosis included shoulder region AC arthralgia. Authorization was requested on 3/23/15 for right shoulder arthroscopic acromioplasty, rotator cuff repair, and debridement of calcium deposit, post-operative physical therapy (6-sessions), Norco 7.5/325mg #30, post-operative UltraSling, and post-operative follow-up visit.

The 3/31/15 utilization review non-certified the request for right shoulder arthroscopic acromioplasty, rotator cuff repair, and debridement of calcium deposit and associated surgical requests as there was no documentation of painful arc of motion, pain at night, or rotator cuff weakness, and no imaging report was documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopic Acromioplasty, Rotator Cuff Repair, Debridement of Calcium Deposit: 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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for impingement syndrome; Surgery for rotator cuff repair.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For impingement surgery or rotator cuff repair, guidelines recommend conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and rotator cuff repair that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. Guideline criteria have not been met. This injured worker presents with focal right shoulder pain over the AC joint. Clinical exam findings documented full range of motion, no evidence of weakness, and negative impingement signs. There is no evidence of a positive diagnostic injection test. There is imaging evidence of minimal rotator cuff tearing and calcific tendinitis. There are no clear imaging findings of impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Post-Operative Physical Therapy (6-sessions, 2 times a week for 3 weeks): 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Norco 7.5/325mg, #30: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-Operative UltraSling: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-Operative Follow-Up Visit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Office visits.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.