

Case Number:	CM15-0083781		
Date Assigned:	05/06/2015	Date of Injury:	12/11/2012
Decision Date:	08/06/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	05/01/2015

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

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 55 year old male, who sustained an industrial injury on 12/11/12. The mechanism of injury was not noted. The diagnoses have included right shoulder tendinitis, right biceps tendinitis and right acromioclavicular joint arthritis. Treatment to date has included medications, cortisone injections, and physical therapy and activity modifications. The diagnostic testing that was performed included right shoulder Magnetic Resonance Imaging (MRI) dated 5/23/13 that revealed moderate to severe tendinosis with partial sided articular tearing. There was a nearly full thickness tear of the subscapularis tendon. There is degeneration of the labrum and moderate to severe acromion with joint arthrosis. Currently, as per the physician progress note dated 4/3/15, the injured worker complains of persistent pain and stiffness in the right shoulder. He reports that he has not had significant improvement of the pain in the right shoulder following a course of physical therapy and cortisone injection. Physical exam revealed that on the right shoulder the injured worker can forward flex his shoulder 160 degrees, abduct right shoulder 140 degrees, there was a positive impingement sign, positive abduction sign and tenderness over the biceps tendon. The previous physical therapy sessions were noted in the records. Work status is total temporary disability for one month. The physician noted that the injured worker suffers with ongoing pain in the right shoulder and has undergone extensive non-operative care including injection, activity modifications, physical therapy, analgesic and anti-inflammatory medications and the symptoms persist. The physician requested treatments included Right shoulder arthroscopy, subacromial decompression, rotator cuff repair, superior labral tear from anterior to posterior (SLAP) repair, open biceps tenodesis,

excision distal clavicle, assistant surgeon, post -operative physical therapy 2 times a week for 6 weeks right shoulder, associated surgical services Ice machine, associated surgical services deluxe arm sling and pre-operative EKG, and labs (CBC, Metabolic chemistry).

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, subacromial decompression, rotator cuff repair, SLAP repair, open biceps tenodesis, excision distal clavicle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 204, 209, 211, and 214, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Rotator cuff repair, SLAP lesion diagnosis.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 209-210.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. 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 4/3/15. 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 4/3/15 does not demonstrate evidence satisfying the above criteria. Therefore the request is not medically necessary.

Associated surgical services Ice machine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Continuous-flow cryotherapy.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical services deluxe arm sling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), immobilization.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): s 212-214.

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