

Case Number:	CM14-0117031		
Date Assigned:	09/16/2014	Date of Injury:	12/11/2003
Decision Date:	10/20/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/24/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Claimant is a 34 year old male with an industrial injury dated 12/11/03. The patient is status post a left shoulder endoscopic subacromial decompression and arthroscopic repair of a partial thickness supraspinatus tear. Magnetic resonance imaging (MRI) of the right shoulder dated 02/04/04 demonstrates that there was no labral tear and mild irregularity along the superior glenoid; but the rotator cuff was intact. MRI of the left shoulder dated 02/15/13 provides evidence for a superior labral anterior-posterior lesion, along with a healed supraspinatus tendon. Exam note 05/28/14 states the patient returns with left shoulder pain. Upon physical exam the patient demonstrated decreased strength, and close to full range of motion with pain. The patient had tenderness surrounding the left shoulder. The supraspinatus and SLAP tests were both positive. Conservative treatments have included activity modification and medication which are not aiding to the pain relief. Treatment includes a left shoulder arthroscopy with possible rotator cuff repair, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

SX diagnostic left shoulder arthroscopy with possible rotator cuff repair, biceps tenotomy vs tendonitis, labral repair, subacromial decompression, dista clavicle excision: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff repair.

Decision rationale: According to the American College of Occupational and Environmental Medicine (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. The Official Disability Guidelines (ODG) Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 5/28/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 5/28/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. The requested treatment is not medically necessary and appropriate.

SX post op cryotherapy left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment index, 12th edition (web); 2014 Shoulder, 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.

SX post op DME abduction pillow sling, left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment index, 12th edition (web); 2014 Shoulder, postoperative abduction pillow sling

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.

SX facility outpatient at advanced ambulatory center: Upheld

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

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.

SX post op physical therapy 12 sessions for left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (MTUS), 2009, Post surgical rehabilitation

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.