

Case Number:	CM14-0147859		
Date Assigned:	09/15/2014	Date of Injury:	12/11/2012
Decision Date:	10/24/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/11/2014

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 Surgeon, has a subspecialty in Hand Surgeon and is licensed to practice in Texas and Georgia. 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:

The injured worker is a 52-year-old male who reported an injury on 12/11/2012. The mechanism of injury was a slip and fall. The diagnoses included torn medial meniscus right knee, status post partial medial meniscectomy right knee, internal derangement left shoulder, mild tendinosis exterior tendon right elbow. The previous treatments included cortisone injections, surgery, medication, and physical therapy. The diagnostic testing included an MRI of the right knee, CT scan of the cervical spine, and MRI of the left shoulder. Upon the physical exam dated 05/12/2014, it was reported the injured worker complained of the inability to perform his own self-care. He complains of constant aching in the left shoulder and localized pain in the subacromial area. He noted the pain radiated down his arm to his left elbow. Upon the physical examination of the left shoulder, the provider noted there was subacromial tenderness and minimal subacromial crepitation. The range of motion was noted to be flexion at 110 degrees and extension at 40 degrees. The provider noted the injured worker had normal sensory of the upper extremities. The provided noted the injured worker had full range of motion without pain or tenderness in the left elbow. The MRI dated 01/09/2013 revealed osteoarthritis of the left glenohumeral joint with areas of chondromalacia involving the humeral head and glenoid, subchondral cystic changes in the glenoid, and mild osteoarthritis of the left acromioclavicular joint. The provider requested an arthroscopic surgery of the left shoulder, pre-op labs, and postop physical therapy. However, a rationale is not submitted for clinical review. The request for authorization was submitted and dated on 07/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy with Lysis of Adhesion Labral Repair or Resection, Possible Subacromial Decompression (SAD) Acromioplasty with Distal Clavicle Resection (DCR), Possible Biceps Tenodesis: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Shoulder, Labrum Tear Surgery

Decision rationale: The request for left shoulder arthroscopy with lysis of adhesion, labral repair with resection, possible subacromial decompression, acromioplasty with distal clavicle resection, possible biceps tenodesis is not medically necessary. The CA MTUS/ACOEM Guidelines state rotator cuff repair is indicated for significant tears that impair activities by causing weakness of the arm, elevation, or rotation, particularly acutely in younger workers. Rotator cuff tears are frequently partial thickness tears or smaller, full thickness tears. For partial thickness rotator cuff tears and small full thickness tears presenting primarily as an impingement, surgery is reserved for cases failing conservative therapy for 3 months. The preferred surgery is usually arthroscopic decompression, which involves debridement of inflamed tissues, burning of the anterior acromion, lysis, and sometimes removal of the coracoacromial ligament and possibly removal of the outer clavicle. Surgery is not indicated for patients with mild symptoms or those whose activities are not limited. In addition the Official Disability Guidelines recommend for Labral Tears the failure of conservative treatment for 3 months, fraying and degeneration of the superior labrum, normal biceps, no detachment, or more than 50 percent of the tendon is involved, vertical tear, bucket-handle tear of the superior labrum which extends into biceps, intrasubstance tear. Within the clinical documentation the provider noted the injured worker had subacromial tenderness and minimal subacromial crepitation with the range of motion of abduction to 90 degrees and adduction of 50 degrees. The MRI dated 01/09/2013 revealed osteoarthritis of the left glenohumeral joint with areas of chondromalacia involving the humeral head and glenoid, sub-chondral cystic changes in the glenoid, and mild osteoarthritis of the left acromioclavicular joint. However, the imaging did not corroborate the findings of a tear. The clinical documentation submitted did not indicate the injured worker had failed conservative treatment including medications and injections for at least 3 to 6 months. Therefore, the request is not medically necessary.

Pre-Op Labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter

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 Physical Therapy Three times a week for four weeks for the Left Shoulder:
Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.
Decision based on Non-MTUS Citation ODG Shoulder Chapter

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.