

Case Number:	CM14-0172510		
Date Assigned:	10/23/2014	Date of Injury:	09/29/2003
Decision Date:	11/25/2014	UR Denial Date:	10/04/2014
Priority:	Standard	Application Received:	10/17/2014

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 Texas. 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 65-year-old male who reported injury on 09/29/2003. The mechanism of injury was due to a fall off a ladder while changing a light bulb. The injured worker has a diagnosis of rotator cuff sprain. His medical treatment consists of surgery, physical therapy, the use of an unloader brace, injections and medication therapy. Medications include tramadol and Theramine cream. On 08/08/2014, the injured worker underwent an MRI of the right shoulder without contrast which revealed postoperative changes of the rotator cuff repair with ferromagnetic artifact partially limiting evaluation. There was marked attenuation with evidence of transmural re-tear of the distal supraspinatus tendon with retraction of the tendon by 2.5 to 3 cm. The tendon was markedly attenuated posteriorly at the conjoined tendon insertion with evidence of intermittent grade partial articular surface disruption and tendinosis of the infraspinatus tendon. Moderate subscapularis tendinosis. Mild to moderate supraspinatus and infraspinatus muscle volume loss with mild atrophy of the superior subscapularis muscle. It was also noticed that there was degeneration of the superior labrum extending into the anterior and posterior margins of the labrum without a defined tear. There were postoperative changes at the AC joint with evidence of subacromial scarring. Scarring and thickening of the coracoacromial ligament. Progress report dated 08/12/2014 indicated that the injured worker had pain to the right shoulder. There was no documented evidence of range of motion, functional deficits, sensory deficits or motor strength to the right shoulder. Medical treatment plan is for the injured worker to undergo arthroscopic surgery of the right shoulder with possible arthroplasty with rotator cuff repair and possible augmentation with a biologic graft. Rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Arthroscopy with rotator cuff repair, right shoulder QTY: 1:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

Decision rationale: The request for associated surgical service: Arthroscopy with rotator cuff repair, right shoulder is not medically necessary. It was noted in the progress note dated 08/12/2014 that the injured worker had changes of previous rotator cuff repair with marked attenuation and evidence of a transmural re-tear of the distal supraspinatus tendon with retraction by 2.5 to 3 cm. However, the submitted documentation lacked any indication of the injured worker having trialed and failed conservative treatment for the last 3 months. There was also no indication in the progress note of any activity limitation. Additionally, there was no submitted documentation showing that the injured worker had undergone counseling regarding likely outcomes, risks and benefits. Given the above, and lack of documented evidence submitted for review, the request for arthroscopy with rotator cuff repair is not medically necessary.

Associated surgical service: Possible arthroplasty and augmentation with biologic graft, right shoulder QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Arthroplasty (shoulder): Indications for Surgery

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: Post-operative physical therapy, 12 sessions, right shoulder:
Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines
Page(s): 27.

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: Upheld

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

Associated surgical service: Cyotherapy QTY: 1: Upheld

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