

Case Number:	CM14-0183443		
Date Assigned:	11/10/2014	Date of Injury:	01/10/2012
Decision Date:	12/15/2014	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/04/2014

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 and is licensed to practice in Minnesota. 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 56 year old female with a history of neck pain and bilateral shoulder pain, left greater than right. She underwent a right shoulder arthroscopy on 12/05/2012 with subacromial decompression, distal clavicle excision, debridement of the bursa and a partial thickness rotator cuff tear. Other issues at that time included bilateral upper extremity radiculopathy, right elbow tendinitis, right cubital tunnel syndrome and left carpal tunnel syndrome. She underwent an ultrasound evaluation of the painful left shoulder and was found to have a rotator cuff tear with impingement and acromioclavicular arthritis. Arthroscopy of the left shoulder was performed on 2/19/2014 with subacromial decompression, debridement of a partial thickness rotator cuff tear, debridement of a SLAP lesion, and a Mumford procedure. The findings included severe acromioclavicular arthritis, Impingement syndrome, SLAP tear and partial thickness undersurface supraspinatus tear. Post-operatively CPM was utilized and physical therapy started on 3/10/2014. The physical therapy notes indicate failure to improve postoperatively with persisting shoulder pain, limitation of range of motion, and muscle weakness. In addition the worker had limited and painful cervical motion with associated tenderness. An MR arthrogram of the left shoulder dated 9/2/2014 was said to show evidence of partial delamination of the subscapularis with a partial thickness tear, and mild glenohumeral arthritis. There were no labral tears seen. Mild narrowing of the supraspinatus outlet was noted. There is continuing pain in the left shoulder with impingement, tenderness, weakness, and limitation of motion. The disputed issues pertain to a request for arthroscopic re-evaluation of the left shoulder with retro-coracoid decompression, rotator cuff and/or subscapularis debridement and/or repair. The UR non-certified the request for lack of clinical or imaging evidence of retro-coracoid impingement, and lack of documentation identifying that as a pain generator. No

diagnostic injections were documented. Other disputed issues pertain to associated surgical services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Arthroscopic re-evaluation of the left shoulder, arthroscopic retrocoracoid decompression, rotator cuff/subscapularis debridement and/or repair:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 211. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Indications for Surgery: Anterior Acromioplasty, Rotator Cuff Repair, Shoulder: Acute and Chronic

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 213.

Decision rationale: California MTUS guidelines indicate surgical considerations if there is clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. Surgical considerations depend on identification of the pain generator which needs to be a surgical lesion. The requested procedure of retro-coracoid decompression should be of benefit if retro-coracoid impingement is confirmed as the pain generator. However, there is no documentation of this being the case. An injection of local anesthetic into the retro-coracoid space to identify the pain generator or imaging evidence of retro-coracoid impingement is not available. The previous surgical procedure of rotator cuff debridement and subacromial decompression was not effective and there is no indication that a repeat procedure should be any different. In light of the above, the request for arthroscopic re-evaluation of the left shoulder, arthroscopic retro-coracoid decompression, and rotator cuff/subscapularis debridement and/or repair is not medically necessary.

Associated surgical service: Pre-Operative Medical Clearance: 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.

Associated surgical service: 12 sessions of post-operative rehabilitative therapy: 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.

Associated surgical service: 1 home continuous passive motion device (CPM): 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.

Associated surgical service: 45 days use of surgi-stim unit: 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.

Associated surgical service: 90 days use of coolcare cold therapy: 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.