

Case Number:	CM14-0028356		
Date Assigned:	07/23/2014	Date of Injury:	06/09/2011
Decision Date:	08/27/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/06/2014

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 Pennsylvania. 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 claimant is a 62-year-old who injured her right shoulder on 06/09/11 and is status post rotator cuff repair. The clinical records provided for review include the report of an MRI dated 10/24/13 identifying postsurgical changes at the supraspinatus with no evidence of rotator cuff tearing. There was a low grade partial thickness intrasubstance tear of the anterior fibers of infraspinatus tendon with mild osteoarthritic changes at the acromioclavicular joint. The report of an office visit dated 02/25/14 describes continued tenderness with physical examination showing 4/5 strength, positive O'Brien's, Neer, Hawkins, Jobe and liftoff testing. Range of motion was 150 degrees of forward flexion and 45 degrees of external rotation. Based on failed conservative care including anti-inflammatory agents and physical therapy, a rotator cuff procedure was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic complete synovectomy, extensive debridement, decompression and rotator cuff repair: 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: Based on California ACOEM Guidelines revision rotator cuff repair, debridement and decompressive surgery would not be indicated. ACOEM Guidelines recommends rotator cuff repair for significant tears that impair activities by causing weakness of arm elevation or rotation. Presently, there is a lack of documentation of conservative care to include recent injection therapy. The postoperative MRI report fails to demonstrate acute rotator cuff pathology with no indication of full thickness tearing or recurrent tearing to the cuff. The acute need of operative intervention to this individual's right shoulder is not medically necessary.

Ultrasling x 7 to 14 days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Postoperative abduction pillow sling Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. (Ticker, 2008).

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

Cold therapy unit x 7 to 14 days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205,555-556. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Continuous-flow cryotherapy Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. (Hubbard, 2004) (Oswehr, 2002) (Singh, 2001) See the Knee Chapter for more information and references.

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

Postoperative physical therapy 2x6 for the right: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Pr-operative medical clearance; labs: PT (INR), PTT, UA, CBC with Diff and BMP:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Independent Medical Examinations and Consultations, page 127.

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