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| Case Number: | CM14-0211177 | | |
| Date Assigned: | 12/24/2014 | Date of Injury: | 05/16/2013 |
| Decision Date: | 02/20/2015 | UR Denial Date: | 12/09/2014 |
| Priority: | Standard | Application Received: | 12/16/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 female who reported an injury on 05/16/2013. The mechanism of injury was not provided. Her diagnoses include spinal stenosis to the lumbar region without neurogenic claudication, lumbar spine strain with degenerative disc disease, right shoulder rotator cuff tear, cephalgia, bilateral wrist bursal joint arthritis, chronic right scaphoid nonunion, bilateral carpal tunnel syndrome, right medial epicondylitis, and cervical spine strain with degenerative disc disease. Past treatments were noted to include physical therapy and medications. On 12/02/2014, the injured worker reported occasional neck pain that radiated to the right side of her head and shoulder. She rated her right shoulder and right scapula pain 8/10 to 9/10. Upon physical examination, it was noted the injured worker had increasing pain towards terminal range of motion on the right side. Relevant medications were noted to include Ultram and Prilosec. The treatment plan was noted to include medications, physical therapy, a pain management consultation, and surgery. A request was received for right shoulder arthroscopy, subacromial decompression, intra-articular surgery, right shoulder rotator cuff repair, as an outpatient without a rationale. The Request for Authorization was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, subacromial decompression, intra-articular surgery, right shoulder rotator cuff repair, as an outpatient: 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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Diagnostic arthroscopy, Surgery for impingement syndrome, Surgery for rotator cuff repair.

Decision rationale: The request for right shoulder arthroscopy, subacromial decompression, intra-articular surgery, right shoulder rotator cuff repair, as an outpatient is not medically necessary. According to the California MTUS/ACOEM Guidelines, surgical consideration may be indicated for those who have red flag conditions, activity limitations for more than 4 months, failure to increase function despite exercise programs, and evidence on imaging studies. More specifically, the Official Disability Guidelines indicate that diagnostic arthroscopy is recommended when imaging studies are inconclusive and the injured worker continues to have pain or functional limitation despite previous conservative care. The guidelines also indicate that the criteria for impingement syndrome are documentation noting 3 to 6 months of previous conservative care; pain with active arc motion 90 to 100 degrees and pain at night; weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and a positive impingement sign; and evidence of impingement on imaging studies. Furthermore, the guidelines indicate that surgery for impingement syndrome is not recommended in conjunction with a rotator cuff repair. Finally, the guidelines indicate the criteria for rotator cuff repair for a full thickness rotator cuff are evidence of shoulder pain and inability to elevate the arm and tenderness over the greater tuberosity, weakness with abduction, and imaging studies noting positive deficit. The criteria for partial thickness rotator cuff repair are documentation regarding previous conservative treatment, pain with active arc motion 90 to 130 degrees, and pain at night; weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and a positive impingement sign; and evidence of a deficit in the rotator cuff on imaging studies. The clinical documentation submitted for review did not indicate this injured worker had red flag conditions. Imaging studies were not provided for review to determine the correct pathology this injured worker had. Additionally, it was not noted that this injured worker had pain with active arc motion, pain at night, tenderness over the rotator cuff or anterior acromial area, a positive impingement sign, or weak or absent abduction. Consequently, the request is not supported by the evidence based guidelines. As such, the request for right shoulder arthroscopy, subacromial decompression, intra-articular surgery, right shoulder rotator cuff repair, as an outpatient is not medically necessary.