

Case Number:	CM15-0016345		
Date Assigned:	02/04/2015	Date of Injury:	01/20/2014
Decision Date:	03/31/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/28/2015

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

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 male who sustained an industrial related injury on 1/20/14 after a 15 foot fall. The injured worker had complaints of left shoulder pain per exam note of 12/20/14. Physical examination findings included left shoulder forward flexion to 140 degrees, abduction to 120 degrees, external rotation to 50 degrees. Neer's/Hawkin's and Speed's/Yerganson's signs were positive. A left shoulder MRI was noted to have revealed an oblique tear of the supraspinatus tendon, vertical tear of the superior glenoid labrum, and fluid collection in the subcoracoid recess comparable with subcoracoid bursitis. Diagnoses were adhesive capsulitis of the shoulder, shoulder tendinitis, and shoulder rotator cuff syndrome. Treatment included surgery for a left wrist fracture. The injured worker wears a wrist splint but has not had any physiotherapy. The treating physician requested authorization for a left shoulder arthroscopy, rotator cuff repair, subacromial decompression, distal clavicle resection and biceps surgery. On 12/29/14 the request was modified to non-certify the distal clavicle resection and biceps surgery. The utilization review (UR) physician cited the Medical Treatment Utilization Schedule guidelines and the Official Disability Guidelines. The UR physician noted a MRI revealed the biceps tendon was intact therefore the bicep surgery was non-certified. Regarding the distal clavicle resection, the guideline criteria were not met as no imaging revealed evidence of significant AC joint degeneration and at least 6 weeks of care. Therefore the distal clavicle resection was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy, Rotator Cuff Repair, Subacromial Decompression, Distal Clavicle Resection And Bicipets Surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG, Shoulder Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Surgery for rotator cuff repair

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 12/20/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 12/20/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is for non-certification for the requested procedure.