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| Case Number: | CM15-0075340 | | |
| Date Assigned: | 04/27/2015 | Date of Injury: | 08/21/2008 |
| Decision Date: | 05/22/2015 | UR Denial Date: | 03/17/2015 |
| Priority: | Standard | Application Received: | 04/20/2015 |

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, Indiana, Oregon
 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 51 year old male, who sustained an industrial injury on 08/21/2008. He reported injuries after a motor vehicle accident. The injured worker is currently diagnosed as having depression, migraine, bursitis of knee, lower leg osteoarthritis, rotator cuff shoulder syndrome, chronic neck pain, pain in shoulder, adhesive capsulitis of shoulder, complete rotator cuff rupture, wrist sprain/strain, and status post repair of rotator cuff tear. Treatment and diagnostics to date has included left shoulder MRI, right shoulder MRI, left shoulder surgery, left wrist surgery, therapy, and medications. In a progress note dated 10/28/2010, the injured worker presented with complaints of right shoulder pain with progressive worsening. According to the request for authorization, the treating physician reported requesting authorization for retro arthroscopic surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Status post left shoulder revision arthroscopy with revision subacromial decompression:
 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) shoulder.

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. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 2010. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 2010 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. In this case, there is a 2010 pre-op note for the Right shoulder and an operative report only for the left shoulder with no supporting documentation. Therefore, the request is not medically necessary.

Acromioclavicular joint decompression: 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) shoulder.

Decision rationale: CA MTUS/ACOEM is silent on the issue of parital claviclectomy. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for posttraumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case the exam note from 201 and there is no imaging showing ac joint arthrosis. Therefore, the determination is not medically necessary.

Mini open revision repair of rotator cuff: 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) shoulder.

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 2010 do not demonstrate 4 months of failure of activity modification. The physical exam from 2010 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore, the determination is not medically necessary.