

Case Number:	CM14-0126542		
Date Assigned:	09/23/2014	Date of Injury:	11/01/2013
Decision Date:	11/05/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/08/2014

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, Hand Surgeon and is licensed to practice in Texas. 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 46-year-old female with a reported date of injury on 07/12/2013. The mechanism of injury was noted to be from repetitive trauma. Her diagnoses were noted to include bilateral shoulder strain and right shoulder rotator cuff syndrome. Her previous treatments were noted to include physical therapy, steroid injections, and medications. The progress note dated 06/25/2014 revealed complaints of continuous bilateral shoulder pain which radiated to the arms and hands at finger level. The injured worker reported popping, stiffness, muscle knots, and instability to both shoulders. Her pain increased with reaching overhead, lifting, carrying, pushing, pulling, and lying on her sides. She rated her bilateral shoulder pain as a 9/10. The physical examination of the right shoulder revealed decreased range of motion. Palpation of the trapezius muscles revealed tenderness and hypertonicity bilaterally. The Neer impingement and Hawkins impingement tests were positive. The provider indicated an MRI of the right shoulder performed 10/05/2013 that revealed tendinopathy of the supraspinatus without discrete tear and mild acromioclavicular joint arthrosis. The Request for Authorization form was not submitted within the medical records. The request was for a right shoulder arthroscopy and subacromial decompression for right shoulder pain, preoperative clearance, right shoulder sling, polar care unit times 7 days' rental, postoperative physical therapy 2 x6, Ultram (tramadol 50 mg) tablets #90, sig; 1 to 2 tablets by mouth every 6 to 8 hours as needed for pain with no refill, Keratek gel, 4 ounce, for postoperative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy and Subacromial Decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): pages 210 - 211. Decision based on Non-MTUS Citation ODG, Shoulder: Indication for Surgery, Acromioplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211..

Decision rationale: The injured worker has been diagnosed with tendinopathy of the supraspinatus without a discrete tear, and mild acromioclavicular joint osteoarthritis, with a positive Neer's impingement and Hawkins impingement tests, has attempted physical therapy and steroid injections. The California MTUS/ACOEM Guidelines state rotator cuff repair is indicated for significant tears that impair activities caused by weakness of arm elevation or rotation, particularly in acute younger workers. Rotator cuff tears are frequency a partial thickness or smaller full thickness tears. For partial thickness rotator cuff tears and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The preferred procedure is usually arthroscopic decompression, which involved debridement of inflamed tissue, burring of the anterior acromion, lysis and sometimes removal of the coracoacromial ligament, and possibly removal of the outer clavicle. Surgery is not indicated for patients with mild symptoms or those whose activities are not limited. Lesions of rotator cuffs are a continuum from mild supraspinatus tendon degeneration to complete ruptures. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment, but without surgical risks. Studies evaluating the results of conservative treatment of full thickness rotator cuff tears have shown an 80 to 86% success rate for patients presenting within 3 months of injury. The efficacy of arthroscopic decompression for full thickness tears depends on the size of the tear; 1 study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes for rotator cuff tears are much better in younger patients than in older patients, who may be suffering from degenerative changes of the rotator cuff. Surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or for those who have no activity limitation. Conservative care, including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. Because this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendinitis, also refer to the previous discussion of rotator cuff tears. The injured worker has attempted previous conservative measures with physical therapy and steroid injections to the right shoulder. The documentation provided indicated a decreased range of motion and a positive Neer's and Hawkins. The injured worker has indications consistent with the need for shoulder arthroscopic decompression; however, the official MRI report of the right shoulder was not submitted within the medical records. Therefore, the request is not medically necessary.

Pre-Operative 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.

Right Shoulder sling: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter Immobilization

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.

Polar Care Unit x7 days rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS/ ODG / multiple chapters Cervical Shoulder, Lumbar and Knee: ODG

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.

Post - Operative Physical Therapy 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): page 27.

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.

Ultram (Tramadol 50mg) Tabs #90, Sig; one to two tablets by mouth every 6-8 hours as needed for pain with no refill.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain Guide; Tramadol (Ultram) Page(s): page 119.

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.

Kera-Tek gel 4oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA/MTUS; Topical Analgesics Page(s): page 117 - 119.

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.