

Case Number:	CM14-0161552		
Date Assigned:	10/24/2014	Date of Injury:	08/10/2000
Decision Date:	11/25/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/01/2014

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 California. 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:

This 58-year-old female registered nurse sustained an industrial injury on 8/10/2000. Injury occurred while assisting in the transfer of a patient from her bed after a cesarean section. Past surgical history was positive for cervical fusion C4-C7 on 3/22/09. Past medical history was positive for asthma, hypertension, and irregular heartbeats. The 8/14/14 orthopedic report cited on-going left anterior and lateral shoulder pain since the original date of injury. She reported that the shoulder occasionally popped out of the socket, especially with rotation of her arm. Pain was worsened with use of the arm and shoulder movement. Additional complaints included neck spasms, and intermittent numbness and tingling of the shoulder. Conservative treatment, including rest, pain medication, and anti-inflammatory medication, have provided relief for her. Physical exam documented full shoulder range of motion, significant acromioclavicular (AC) joint tenderness, moderate subacromial tenderness, and intact strength. There was 2+ multidirectional instability on instability testing. The treatment plan documented an ultrasound guided glenohumeral joint Lidocaine injection with dramatic pain relief. The patient wished to proceed with arthroscopic surgery. The 9/5/14 left shoulder MRI impression documented severe supraspinatus tendinosis extending to the anterior leading edge with thin linear interstitial tearing and minimal adjacent subacromial/subdeltoid bursitis. There was moderate infraspinatus and mild subscapularis tendinosis with no evidence of full thickness rotator cuff tear. There was intermediate to low signal intensity scarring of the inferior glenohumeral ligament. There was moderate tendinosis intra-articular long head biceps tendon with longitudinal interstitial tearing extending to the biceps tendon anchor. There was intermediate signal intensity degeneration of the anterior superior, posterior superior and superior glenoid labrum with pronounced attenuation of the entire posterior glenoid labrum. There was moderate to severe AC joint arthrosis. The 9/15/14 treating physician report cited left shoulder pain and sensation of the left shoulder

popping out of the socket. Physical exam documented full range of motion, some AC joint tenderness, mild lateral subacromial tenderness, and positive impingement and apprehension tests. There was 2+ instability noted. The diagnosis was left shoulder labral tear, glenohumeral instability, biceps tendinosis, and AC joint arthritis. Authorization was requested for left shoulder arthroscopy with debridement, possible labral repair, possible rotator cuff repair, possible biceps tenodesis, subacromial decompression, and distal clavicle resection with associated visits, medications (dispensed), physical therapy, and durable medical equipment. The 9/23/14 utilization review denied the left shoulder surgery and associated requests as there was no evidence of 3 to 6 months of recent conservative treatment consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy with debridement, possible labral repair, possible rotator cuff repair, possible biceps tenodesis, subacromial decompression , and distal clavicle resection, as outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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, Surgery for impingement syndrome, Surgery for SLAP lesions

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. The ODG state that surgical intervention may be considered for patients with SLAP lesions failing conservative treatment. Guideline criteria have not been met. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including steroid injections and physical therapy exercise, and failure has not been submitted. Therefore, this request is not medically necessary.

Pre-operative office visit (appointment with [REDACTED]): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopedic Surgeons

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, <Insert Topic (for example Total Knee Arthroplasty)> Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38

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

Norco, 10-325mg #60, 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-80, 91.

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

Naproxen 550mg #60, 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

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

Zolpidem 5mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Zolpidem (Ambien®)

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

Zofran 8mg #10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice guidelines for postanesthetic care: an updated report by the American Society of Anesthesiologists Task Force on Postanesthetic Care. *Anesthesiology*. 2013 Feb;118(2):291-307

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

Colace 100mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: McKay SL, Fravel M, Scanlon C. Management of constipation. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core; 2009 Oct. 51 p

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

Four (4) Post-operative office visits (appointments with [REDACTED] within [REDACTED]):
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Office visits

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

Twelve (12) Post-operative physical therapy visits, 2 week x 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

DME: 2 week rental of Game Ready Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Cold compression therapy

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

DME: Purchase of shoulder immobilizer: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213.

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