

Case Number:	CM14-0171691		
Date Assigned:	10/23/2014	Date of Injury:	07/18/2012
Decision Date:	11/21/2014	UR Denial Date:	10/09/2014
Priority:	Standard	Application Received:	10/17/2014

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 Orthopaedic 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 46-year-old female supervisor/manager sustained an industrial injury on 7/18/12, due to repetitive work activities. Past surgical history was positive for diabetes, migraines, and anemia. The 11/28/12 bilateral shoulder ultrasound report documented the left shoulder was evaluated for comparison and was found to have a sharply marginated defect along the inferior articular surface of the distal supraspinatus tendon consistent with degeneration or perhaps a partial thickness tear with approximately 25% of the tendon thickness involved. There was no communication with any surface. The remainder of the left shoulder exam was within normal limits. A left shoulder subacromial injection was documented on 5/7/13 with short term benefit. The 7/30/14 left shoulder MRI impression documented supraspinatus tendinosis and peritendinitis with a partial thickness tear. There was no full thickness rotator cuff tear identified. There was mild arthropathy of the acromioclavicular joint. The 9/16/14 treating physician report cited left shoulder pain. Physical exam documented tenderness to palpation over the acromioclavicular joint, supraspinatus tendon, and anterior capsule, There was a positive impingement and cross arm tests, 5/5 left upper extremity strength, and decreased range of motion. The treatment plan recommended left shoulder surgery. The 9/8/14 orthopedic report cited persistent right shoulder pain. Physical exam documented left shoulder range of motion as flexion 145, abduction 145, extension 40, adduction 40, external rotation 90, and internal rotation 60 degrees. There was severe supraspinatus tenderness, moderate greater tuberosity tenderness, and mild biceps tenderness. There was subacromial crepitus and general 4/5 weakness. Acromioclavicular joint compression and impingement tests were positive. The treatment plan recommended arthroscopic left shoulder decompression, distal clavicle resection, and rotator cuff debridement and/or repair. The 10/9/14 utilization review denied right shoulder surgery and associated requests as there was no submitted imaging demonstrating rotator cuff pathology or

positive findings correlated with objective findings, and no evidence that the patient had exhausted conservative treatment. The 10/28/14 appeal letter reviewed the imaging findings documenting left supraspinatus partial thickness tear and mild acromioclavicular arthropathy. Persistent pain over the left shoulder and right wrist with associated numbness were reported. Conservative treatment had included physical therapy, medications, activity modification, home exercise program, and bracing performed within a year but failed to manage symptoms. Physical exam findings were restated. The treatment plan requested authorization for left shoulder surgery and surgical consultation for right carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic left shoulder decompression, distal clavicle resection, rotator cuff debridement and/or repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Procedure Summary, Indications for Surgery, Rotator cuff repair; Acromioplasty

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, Partial Claviclectomy, Surgery for rotator cuff repair

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. Guideline criteria have not been met. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial directed to the left shoulder and failure has not been submitted. Therefore, this request is not medically necessary.

Associated surgical service: Post-operative rehabilitative therapy, 3x4: 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.

Associated surgical service: Purchase of home continuous passive motion (CPM) device: 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, Continuous passive motion (CPM)

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

Associated surgical service: Purchase of Surgi-Stim unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

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

Associated surgical service: Purchase of Coolcare cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Procedure Summary

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

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