

Case Number:	CM14-0021213		
Date Assigned:	06/20/2014	Date of Injury:	12/06/2013
Decision Date:	07/28/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/20/2014

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 56-year-old female lead steward sustained an industrial injury on 12/6/13. Injury occurred while pulling and pushing heavy racks and doing overhead reaching. She felt pain and heard a tearing sound in the left arm. The patient had been treated with a sling, analgesics, and home exercise program. The 12/9/13 treating physician report cited moderate left shoulder pain radiating to mid-forearm with intermittent numbness and tingling to left hand and fingers. Left shoulder swelling was reported. Difficulty raising the left arm was documented. Physical exam documented tenderness to palpation over the subacromial space and bicipital groove. Active range of motion testing documented flexion 0, abduction 0, extension 20, external rotation 5, and internal rotation 40 degrees. The treatment plan recommended physical therapy 2x3. The 12/24/13 left shoulder MRI impression documented high grade partial thickness supraspinatus tear, diffuse rotator cuff tendinosis, moderate-large subacromial/subdeltoid bursal collection with synovial thickening, superior and anterior labral degeneration, and biceps tendinosis. The 1/13/14 left shoulder x-ray showed moderate to severe acromioclavicular (AC) joint hypertrophic degenerative joint changes. The 1/27/14 treating physician report cited constant grade 6-7/10 pain and burning sensation in the left arm, radiating down to the elbow. Left shoulder range of motion testing documented flexion 75, abduction 75, external rotation 50, internal rotation 20, extension 30, and adduction 10. There was pain at end range with guarding during active range of motion. There was weak left shoulder flexion, abduction. The diagnosis was left shoulder rotator cuff tear, subacromial impingement syndrome, and AC osteoarthritis. Left shoulder arthroscopic repair was recommended. The patient was capable of modified work. The 2/12/14 utilization review denied the request for left shoulder surgery and associated services given failure to meet guideline criteria relative to conservative treatment. The 2/24/14 progress report cited moderate relief for 3 weeks status post cortisone injection on 1/20/14. Left

shoulder exam documented decreased grip strength, positive impingement sign, and 4/5 weakness. Active range of motion testing documented flexion 80, abduction 70, external rotation 70, external rotation 60, extension 30, and adduction 20. The treatment plan recommended a second cortisone injection and additional physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. Guideline criteria have not been met. The patient was 2 months status post injury at the time of the original utilization review with no evidence of red flag conditions. Guidelines require a conservative treatment period of 4 months and failure to increase strength and range of motion with exercise prior to consideration of surgery. Therefore, this request for left shoulder arthroscopy is not medically necessary.

Left shoulder debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The ACOEM Guidelines for partial thickness rotator cuff tears state that surgery is reserved for cases failed conservative treatment for 3 months. Guideline criteria have not been met. There is no detailed documentation that comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for left shoulder debridement is not medically necessary.

Left shoulder decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The ACOEM Guidelines relative to arthroscopic decompression state that conservative care, including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. There is no detailed documentation that comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for left shoulder decompression is not medically necessary.

Left shoulder rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The ACOEM Guidelines for partial thickness rotator cuff tears state that surgery is reserved for cases failed conservative treatment for 3 months. Guideline criteria have not been met. There is no detailed documentation that comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for left shoulder rotator cuff repair is not medically necessary.

Left shoulder probable distal clavicle excision: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The ACOEM Guidelines state that resection of the outer clavicle is recommended for chronic disabling acromioclavicular joint pain after conservative care. Guidelines require 3 to 6 months of conservative treatment. There is no detailed documentation that comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for left shoulder probable distal clavicle excision is not medically necessary.

In-house medical clearance: 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 Other Medical Treatment Guideline or Medical Evidence: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

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

Preoperative labs: 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 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.

Preoperative chest x-ray: 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 Other Medical Treatment Guideline or Medical Evidence: ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

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

Preoperative electrocardiogram (EKG): 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 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.

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

Cold Therapy Unit: 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, Continuous flow cryotherapy.

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

Shoulder Pulley: 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, Exercises.

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

Ultra Sling: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.

Post-operative physical therapy two times per week for six weeks, for a total of 12 sessions:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.

Prescription of Norco 325: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.