MAXIMUS Federal Services

Case Number:	CM14-0041845		
Date Assigned:	06/30/2014	Date of Injury:	08/04/2011
Decision Date:	07/23/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/08/2014

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 Orthopaedic Surgery and is licensed to practice 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 38-year-old male restaurant general manager sustained an industrial injury on 8/4/11. Injury occurred while lifting overhead. He underwent right shoulder arthroscopy with rotator cuff and SLAP repair on 2/14/12, and a repeat arthroscopy on 11/14/12. The 10/2/13 right shoulder MRI revealed severe acromioclavicular (AC) joint arthropathy, advanced rotator cuff tendinosis without retraction, advanced degenerative change involving the osseous structures, degenerative labral changes, and positive subacromial subdeltoid bursitis. The 1/22/14 treating physician report cited debilitating right shoulder pain brought on by reaching and elevating the arm. Physical exam findings documented active elevation to 100 degrees, passive elevation to 150 degrees, external rotation 70 degrees, and internal rotation to L5. Strength was good but he broke easily with abduction and supraspinatus isolation testing. Pain was noted with abduction arc and external rotation/abduction. There was no pain or tenderness at the AC joint, pain is all anterior and lateral and below the level of the acromion. The treating physician opined persistent pain from rotator cuff scarring, prior labral repair, and the subacromial region. A subacromial joint injection was performed. The 3/5/14 orthopedic report stated that the previous corticosteroid injection was only slightly helpful. There was marked anterolateral shoulder pain that limited reaching and lifting. Physical exam documented good strength but irritability with any elevation of the arm. There was pain with abduction arc maneuver. The patient had tried therapy, injections, and ultrasound without improvement. Arthroscopic debridement with evaluation of the labrum and joint was recommended. The 3/20/14 QME supplemental report recommend an AC joint injection instead of a subacromial injection prior to contemplation of a third operation. The 3/27/14 utilization review denied the request for right shoulder arthroscopy and associated services/items based on an absence of clear clinical exam findings to support the medical

necessity of surgery. The 4/2/14 orthopedic report opined the need for an AC joint injection prior to surgery. Subsequent request for ultrasound guided AC joint injection was noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder Arthroscopy, Manipulation, Decompression: Upheld

Claims Administrator 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 Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, SURGERY FOR IMPINGEMENT SYNDROME.

Decision rationale: The California MTUS does not provide surgical recommendations for chronic shoulder conditions. The Official Disability Guidelines state that diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Manipulation under anesthesia is under study as an option in adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90), manipulation under anesthesia may be considered. Surgical decompression is recommended when there is positive evidence of impingement, including a diagnostic injection test. Guideline criteria have not been met at this time. Surgical opinions have differed in this case regarding the need for a third procedure. An AC joint diagnostic injection test has been recommended and not yet completed. There is no evidence of adhesive capsulitis to support manipulation. Therefore, this request for right shoulder arthroscopy, manipulation, and decompression is not medically necessary.

12 sessions post-op physical therapy: 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: As the request for right shoulder arthroscopy, manipulation, and decompression is not medically necessary, the request for 12 sessions of post-op physical therapy is also not medically necessary.

Tens Unit 4- lead: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy (TENS) Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, POST-OPERATIVE PAIN (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION) Page(s): 116-117.

Decision rationale: As the request for right shoulder arthroscopy, manipulation, and decompression is not medically necessary, the request for a 4-lead TENS unit is also not medically necessary.

DME polar care, sling: 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), Continuous-flow Cryotherapy, Shoulder Chapter.

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, POSTOPERATIVE ABDUCTION PILLOW SLING.

Decision rationale: As the request for right shoulder arthroscopy, manipulation, and decompression is not medically necessary, the request for DME (polar and sling) is also not medically necessary.