

Case Number:	CM14-0081311		
Date Assigned:	08/04/2014	Date of Injury:	10/01/2008
Decision Date:	09/10/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/02/2014

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 47-year-old male drywall taper sustained an industrial injury on 1/27/09. Injury occurred while picking up and lifting tools at work. The patient underwent L5/S1 micro discectomy on 2/2/11 with residual lumbar radiculopathy. The patient underwent right rotator cuff repair on 10/25/12. Records indicated that the patient had on-going low back, neck, right shoulder, and bilateral lower extremity pain. Physical therapy was provided relative to the low back and right shoulder and the patient had completed a functional restoration program (FRP). The 1/13/14 chart note indicated the patient was exercising at a gym on a regular basis. He had range of motion difficulty and weakness in the left shoulder with minimal pain. The 3/10/14 treating physician note indicated the patient had increased left shoulder pain with handling and lifting objects with the left upper extremity. He denied popping. Abduction was limited to 110 degrees. The patient was to continue doing his exercise and stretches. The 5/1/14 left shoulder MRI revealed a small intrasubstance tear of the supraspinatus tendon at the footprint, which did not clearly extend to the articular or bursal surface. There were mild degenerative changes of the acromioclavicular joint. The 5/20/14 treating physician report cited continued left shoulder symptoms. Physical exam documented significant pain upon left shoulder forward flexion, internal rotation and abduction. The patient had not improved despite conservative treatment. A left shoulder Celestone and lidocaine injection was provided. The 5/27/14 treating physician report indicated that the patient had a two year history of left shoulder symptoms that had been treated with physical therapy, cortisone injection, anti-inflammatories, and activity modification. He had pain with provocative testing, abduction and internal rotation, and rotator cuff testing. The treatment plan recommended left shoulder diagnostic arthroscopy with extensive debridement, subacromial decompression, and acromioplasty. The 5/29/14 utilization review denied the left shoulder arthroscopy and associated requests as guideline criteria were not met.

relative to subjective findings, imaging evidence of rotator cuff deficit, and lack of documented conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Diagnostic Arthroscopy with Extensive Debridement, Subacromial Decompression, and Acromioplasty: 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 (Acute & Chronic).

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, Acromioplasty, Surgery for Impingement Syndrome.

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. There is no documentation of current shoulder strength, positive impingement signs, or a positive diagnostic injection test. There was no documentation of response to the 5/20/14 left shoulder steroid injection. The patient has been afforded physical therapy directed to the right shoulder and low back. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment directed specifically to the left shoulder had been tried and failed. Therefore, this request for left shoulder diagnostic arthroscopy with extensive debridement, subacromial decompression, and acromioplasty is not medically necessary.

1 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 (Acute & Chronic).

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: As the request for left shoulder arthroscopic surgery is not medically necessary, the associated request for one cold therapy unit is also not medically necessary.

12 Post Operative Physical Therapy Sessions: 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 left shoulder arthroscopic surgery is not medically necessary, the associated request for 12 post-operative physical therapy sessions is also not medically necessary.

1 Sling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic) Postoperative Abduction Pillow Sling.

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

Decision rationale: As the request for left shoulder arthroscopic surgery is not medically necessary, the associated request for one sling is also not medically necessary.

1 set of Shoulder X - Rays: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: The California MTUS guidelines recommend initial studies when red flag is noted on history or exam raises suspicion of a serious shoulder condition or referred pain. The Official Disability Guidelines radiography guidelines recommended shoulder radiography in acute trauma. The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. Guideline criteria have not been met. There is no compelling reason to support the medical necessity of shoulder x-rays for this patient. An MRI was performed on 5/1/14. The rationale for additional imaging is not documented. Therefore, this request for one set of shoulder x-rays is not medically necessary.

1 Celestone and Lidocaine Injection into the Left Shoulder: Overturned

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 (Acute & Chronic), Steroid Injections.

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

Decision rationale: The California MTUS recommend two or three subacromial cortisone injections over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. Guideline criteria have been met. This patient presents with findings of a small rotator cuff tear and mild acromioclavicular degenerative joint disease. The use of a corticosteroid injection is consistent with guideline-supported conservative treatment. Therefore, the request for one Celestone and Lidocaine injection into the left shoulder performed 5/20/14 was medically necessary.