

Case Number:	CM14-0166895		
Date Assigned:	10/14/2014	Date of Injury:	02/03/2013
Decision Date:	01/20/2015	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/09/2014

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:

According to the records made available for review, this is a 55-year-old female with a 2/3/13 date of injury, and left shoulder arthroscopy with rotator cuff repair in 2013. At the time (6/19/14) of request for authorization for subacromial decompression, left shoulder arthroscopy w/ rotator cuff repair, and labral tear repair, there is documentation of subjective (left shoulder pain associated with numbness and tingling into the entire left upper extremity) and objective (tenderness over the shoulder, decreased left shoulder range of motion, positive Apprehension test, positive Neers test, positive Hawkins Test, positive Speed test, positive Yergason test, and 5/5 motor strength) findings, imaging findings (MRI arthrogram of the left shoulder (11/13/13) report revealed prior rotator cuff repair, contrast in subdeltoid bursa strongly suggests a recurrent rotator cuff tear or surgical defect along the anterior margin of the distal supraspinatus, no definite labral tear, possible mild long head of biceps tendinopathy in the rotator interval, mild acromioclavicular changes), current diagnoses (left impingement syndrome and pain in joint - shoulder region), and treatment to date (medications, physical therapy, treatment with TENS unit, and home exercise program). There is no documentation of failure of additional conservative treatments (cortisone injections); additional subjective clinical findings (pain with active arc motion 90 to 130 degrees and pain at night); and additional objective clinical findings (weak or absent abduction).

IMR ISSUES, DECISIONS AND RATIONALES

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

Subacromial Decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter

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

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery, usually subacromial decompression. 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. Objective exam findings were limited to tenderness and pain with global range of motion. There is no evidence of a painful active arc of motion, weak or absent abduction, or positive impingement sign with a positive diagnostic injection test. There is no current imaging evidence of impingement to support the medical necessity of surgery consistent with guidelines. The treating physician reported that the current medication and home management program were helpful with pain control. Evidence of recent, reasonable and/or comprehensive non-operative treatment protocol trial, including corticosteroid injection and failure has not been submitted. Therefore, this request is not medically necessary.

Left Shoulder Arthroscopy w/ rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM), 2nd Edition, (2004), page(s) 209-211

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical

findings: conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of left impingement syndrome and pain in joint - shoulder region. In addition, there is documentation of failure of conservative treatment (medications and physical therapy). Furthermore, given documentation of imaging findings (MRI arthrogram of the left shoulder identifying contrast in subdeltoid bursa strongly suggests a recurrent rotator cuff tear or surgical defect along the anterior margin of the distal supraspinatus), there is documentation of imaging clinical findings (arthrogram showing positive evidence of deficit in rotator cuff). However, there is no documentation of failure of additional conservative treatments (cortisone injections). In addition, despite documentation of subjective (left shoulder pain associated with numbness and tingling into the entire left upper extremity), there is no documentation of additional subjective clinical findings (pain with active arc motion 90 to 130 degrees and pain at night). Furthermore, despite documentation of objective (tenderness over the shoulder, decreased left shoulder range of motion, positive Apprehension test, positive Neer's test, positive Hawkins Test, positive Speed test, and positive Yergason test) and given documentation of objective (5/5 motor strength) findings, there is no documentation of additional objective clinical findings (weak or absent abduction). Therefore, based on guidelines and a review of the evidence, the request for left shoulder arthroscopy w/ rotator cuff repair is not medically necessary.

Labral tear repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM), 2nd Edition, (2004), page(s) 209-211 Official Disability Guidelines (ODG) Shoulder Chapter, Subacromial Decompression and Manipulation Under Anesthesia

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of left impingement syndrome and pain in joint - shoulder region. In addition, there is documentation of failure of

conservative treatment (medications and physical therapy). However, there is no documentation of failure of additional conservative treatments (cortisone injections). In addition, despite documentation of subjective (left shoulder pain associated with numbness and tingling into the entire left upper extremity), there is no documentation of additional subjective clinical findings (pain with active arc motion 90 to 130 degrees and pain at night). Furthermore, despite documentation of objective (tenderness over the shoulder, decreased left shoulder range of motion, positive Apprehension test, positive Neer's test, positive Hawkins Test, positive Speed test, and positive Yergason test) and given documentation of objective (5/5 motor strength) findings, there is no documentation of additional objective clinical findings (weak or absent abduction). Lastly, given documentation of imaging findings (no definite labral tear), there is no documentation of positive imaging findings. Therefore, based on guidelines and a review of the evidence, the request for labral tear repair is not medically necessary.