

Case Number:	CM14-0198350		
Date Assigned:	12/08/2014	Date of Injury:	04/08/2012
Decision Date:	02/19/2015	UR Denial Date:	11/10/2014
Priority:	Standard	Application Received:	11/25/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 57-year-old male who reported an injury on 04/08/2012. The mechanism of injury was not included. His diagnoses included biceps tenodesis, rotator cuff tendinitis and impingement, possible biceps tendon tear of the right shoulder, acromioclavicular joint right shoulder. His past treatments have included physical therapy, pain medication. Diagnostic studies included an MRI of the bilateral shoulders on 04/15/2013, that indicated a right shoulder impingement, right shoulder acromioclavicular joint arthritis, diffuse labral tearing with a cyst adjacent to the glenoid of the right shoulder, partial tear of the subscapularis tendon of the right shoulder, rotator cuff tendinitis and impingement of the left shoulder, acromioclavicular joint arthritis of the left shoulder, possible partial biceps tearing bilateral shoulders. The progress report dated 03/05/2014, documented the injured worker had complaints of minimal pain. Physical exam findings included resolving ecchymosis, healing wounds. Neurovascular status is intact. Abduction is to 60 degrees, and external rotation with the arm outside is to 30 degrees. His medications included Vicodin. The treatment plan included physical therapy. The rationale for the request was the injured worker injured his right shoulder, and then developed left shoulder pain while favoring the right shoulder, pain persisted and progressively worsened. The Request for Authorization form is signed and dated 10/28/2014 in the medical record.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with subacromial decompression, resection of the distal clavicle and possible biceps tenodesis, resection of the cyst and labral tear: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, SLAP lesion repair, Rotator Cuff Repair

Decision rationale: The request for right shoulder arthroscopy with subacromial decompression, resection of the distal clavicle and possible biceps tenodesis, resection of the cyst and labral tear is not medically necessary. The injured worker, prior to surgery, had complaints of bilateral shoulder pain, difficulty sleeping, and feelings of weakness. The pain was over the front of the shoulder. Postoperatively, he stated he continued to have mild pain but was better than before the surgery. He was sleeping better, but continued to have pain in the right shoulder. Upon examination of the right shoulder, the range of motion of 70 degrees on external rotation with the arm at the side, 160 degrees on forward flexion, 70 degrees on supination and external rotation, and 60 degrees on supination and internal rotation. Tenderness was noted over the impingement area in the acromioclavicular joint, along with possible impingement findings. The ACOEM state that surgery for impingement syndrome is usually arthroscopic decompression. However, this procedure is not indicated for patient with mild symptoms or those who have no limitation of activities. Conservative care, including cortisone injections, should be carried for at least 3 to 6 months prior to considering surgery. The criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome is conservative care for a recommended 3 to 6 months, subjective clinical findings that would include pain with Active arc of motion 90 to 130 degrees, and pain at night, plus objective clinical findings that would include 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, plus imaging clinical findings of conventional x-rays and MRI, ultrasound, or Arthrogram that shows positive evidence of impingement. The ACOEM state that surgery for ruptured biceps tendon at the shoulder is not recommended except as indicted below. Nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendon. When patients having rotator cuff surgery also have a torn biceps tendon, repairing it with tenodesis takes only 10 minutes longer than tenotomy but yields better outcomes. The Official Disability Guidelines state that labral tears or lesions can be treated with anti-inflammatory medications, activity modification, and physical therapy, but if inoperative treatment fails, surgery may be indicated. As the injured worker indicated his pain was better, and there is a lack of documentation regarding conservative treatment along with conventional X-rays, AP and true lateral or axillary view, and MRI with contrast, ultrasound, or Arthrogram that show positive evidence of impingement, the request is not supported. Therefore, the request is not medically necessary.

Assistant surgeon: 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) Low Back, Surgical assistant

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

Pre-operative 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 Official Disability Guidelines (ODG) Low Back, Preoperative testing, general

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

Post-operative physical therapy for the right shoulder, three times weekly for four weeks: 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 Rotator cuff syndrome/Impingement syndrome Page(s): 27.

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

Ultra sling purchase: 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, Post-Op Abduction Pillow Sling

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

Contrast compression unity/Thermacure rental for fourteen days: 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) Knee and Leg, Continuous-flow cryotherapy

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

Purchase of a pad: 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), Knee & Leg Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Durable medical equipment (DME).

Decision rationale: The Official Disability Guidelines state that durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. That definition is defined as equipment which can withstand repeated use, is primarily customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in a patient's home. As the guidelines state, the pad would need to be able to withstand repeated use, as in could normally be rented and used by successive patients. The request for the pad not medically necessary.