MAXIMUS Federal Services

Case Number:	CM14-0201112		
Date Assigned:	12/11/2014	Date of Injury:	04/20/2008
Decision Date:	01/31/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	12/02/2014

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 Physical Medicine Rehabilitation, has a subspecialty in Interventional spine 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:

The patient is a 62-year-old female with date of injury of 04/20/2008. The listed diagnoses from 09/23/2014 are:1. Lumbar spine surgery disorder.2. Cervical region disk disorder, unspecified.3. Bilateral shoulder impingement syndrome.4. Brachial neuritis or radiculitis, NOS.5. Thoracic or lumbosacral neuritis or radiculitis, unspecified.6. Right shoulder supraspinatus tear. According to this report, the patient complains of mild to moderate pain in the bilateral shoulders at a rate of 6/10. Her right shoulder is worse than the left. She had cortisone injections in the past which provided only temporary relief. The patient has also utilized physical therapy in the past. The examination of the right shoulder reveals no surgical incisions, deformity, scarring, atrophy, scapular winging, and scapular dyskinesis. There is tenderness in the deltoid area. Range of motion is 170 upon flexion with pain, 50 upon extension with pain, 180 abduction with pain, 40 adduction with pain, 90 with internal rotation with pain, and 90 with external rotation with pain. Positive for impingement sign and empty can supraspinatus. Dermatome evaluation was equal bilaterally. Reflexes are 2+ bilaterally. Treatment reports from 03/05/2014 to 11/04/2014 were provided for review. The Utilization Review denied the request on 11/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 RIGHT SHOULDER ACROMIOPLASTY AND ROTATOR CUFF REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

MAXIMUS 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, Surgery for impingement syndrome Shoulder Chapter, Surgery for rotator cuff repair

Decision rationale: This patient presents with bilateral shoulder pain. The treater is requesting ONE RIGHT SHOULDER ACROMIOPLASTY AND ROTATOR CUFF REPAIR. The ACOEM Guidelines page 209 has the following indications for shoulder surgery:1. Red flag conditions.2. Activity limitations for more than 4 months, plus existence of surgical lesion.3. Failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion.4. Clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. ODG states that for acromioplasty, the criteria includes conservative care and pain with active arc motion 90 to 130 degrees; pain at night, weak or absent abduction may also demonstrate atrophy; tenderness over the rotator cuff or anterior acromial area; a positive impingement sign and temporary relief of pain with anesthetic injections (diagnostic injection test) plus conventional x-rays, AP and true lateral or axillary view that shows positive evidence of impingement. ODG for rotator cuff repair states, "Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS2. 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.) PLUS3. 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). PLUS4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.The 11/04/2014 report shows that the patient is complaining of significant neck, upper back, and low back pain radiating to the left more than the right lower extremity. The patient is also complaining of right and left shoulder pain, and the treater references an MRI from 2012 that showed rotator cuff tear in the bilateral shoulders. However, this report was not made available for review. Examination of the shoulder shows a positive O'Brien's test bilaterally. Positive Jobe's test bilaterally. Forward flexion is 145 degrees on the right and 150 degrees on the left. External rotation is 60 degrees on the right and 50 degrees on the left. Internal rotation bilaterally is to S1. Push off is poor bilaterally. The records do not show that the patient has had a right shoulder acromioplasty and rotator cuff repair in the past. In this case, the patient does not have a diagnosis of acromial impingement syndrome and she does not present with the required indications for acromioplasty and rotator cuff repair as indicated in the ACOEM and ODG Guidelines. The MRI report to document the clinical necessity for the surgery is not found in the records provided and therfore

there is no way to tell if the ODG imaging criteria has been met. The request IS NOT medically necessary.

1 PRE-OPERATIVE 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 Official Disability Guidelines (ODG) Low Back Chapter on Preoperative Testing

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

1 Home Care assessment for home care assistance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines home health services Page(s): 51.

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

1 DME: Cold therapy unit for 30-45 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder (Acute and 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 chapter on continuous flow cryotherapy

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

1 DME: Sling with abduction pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder (Acute and Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Postoperative abduction pillow sling, Shoulder Chapter

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

18 post op physical therapy sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 26 and 27.

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