

Case Number:	CM14-0203836		
Date Assigned:	12/16/2014	Date of Injury:	01/23/2013
Decision Date:	02/11/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/05/2014

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 Minnesota. 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 injured worker is a 44-year-old female with a reported injury date of 1/23/2013. Per initial orthopedic panel qualified medical evaluation of August 8, 2014 she sustained injury to the right shoulder, right elbow, low back/hips, and bilateral knees while working as a warehouse technician on January 23, 2013 as a result of cumulative trauma. She also reported a fall, landing on the right and left hands, right and left knees on a concrete floor on January 23, 2013. Her current complaints included the right shoulder with symptoms radiating up to the neck and down the right arm. There was numbness and tingling on the top of the right hand. There was weakness and loss of strength of the right arm and right hand. There was a popping sensation of the right shoulder. Symptoms were increased by reaching and lying on that side. Examination of the shoulders on that day revealed flexion of 120 bilaterally, abduction and 110 bilaterally, internal rotation 45 on the right and 60 on the left. External rotation was 70 on the right and 80 on the left. There was positive impingement pain in the right shoulder with resisted abduction and internal rotation. The examiner recommended nonsteroidal anti-inflammatory drugs, physical therapy for the right shoulder for flareups, a corticosteroid injection into the subacromial space and MRI scan of the right shoulder. The MRI scan of the right shoulder without contrast had previously been performed on 5/28/2014 and revealed arthropathy of the acromioclavicular joint, lateral downsloping of the acromion, full-thickness tear of the supraspinatus tendon measuring medial to lateral dimension of 2.1 cm with AP dimension of 1.5 cm. Subscapularis tendon was intact. Long head of biceps tendon was intact. The infraspinatus tendon was intact. No muscle atrophy was noted. Glenoid labrum was unremarkable. The impression was full-thickness tear of supraspinatus tendon, and mild arthritic changes of the acromioclavicular joint. On 10/29/2014 examination revealed tenderness over the deltoid complex, positive Neer and Hawkins-Kennedy testing, 4/5 strength with flexion, extension,

abduction, adduction, internal rotation and external rotation. Range of motion was restricted due to pain. Flexion was 160 and extension 40. Abduction was 160 and adduction 40. Internal rotation was 70 and external rotation 70. Authorization was requested for diagnostic arthroscopy of the right shoulder, possible synovectomy, labral repair, arthroscopic subacromial decompression, distal clavicle excision, and rotator cuff repair. The surgical request was noncertified by utilization review citing guidelines which state that diagnostic arthroscopy is not necessary when the diagnosis is known. The indication for a diagnostic arthroscopy is unclear imaging studies and therefore the request was not supported. In addition a request for 14 day rental of a cold therapy unit exceeded the guideline recommendations of 7 days and as such was not supported. Therefore the request was noncertified. This is now appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder diagnostic arthroscopy, possible synovectomy, labral repair, arthroscopic subacromial decompression, distal clavicle excisions, rotator cuff repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Diagnostic and Partial Claviculectomy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The California MTUS guidelines indicate surgical considerations for failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus existence of a surgical lesion or activity limitation for more than 4 months plus existence of a surgical lesion or if there is clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. The injured worker has a documented rotator cuff tear. Her clinical findings include impingement and chronic pain that has not responded to non-operative treatment including a steroid injection, exercise program, and medications. The full-thickness rotator cuff tear is a lesion that has been shown to benefit from surgical repair. The provider has requested a rotator cuff repair as well as subacromial decompression for management of the impingement syndrome and a lateral claviculectomy for the acromioclavicular arthritis. Based upon these requests, it is clear that the provider is not asking for arthroscopy to make the diagnosis but for treatment of the diagnosed conditions. The need for treatment is supported by guidelines. There has been adequate trial of a preoperative conservative rehabilitation program with corticosteroid injection as well as medications and therapy with documented failure. A denial of treatment based upon the choice of words with respect to the diagnostic arthroscopy is not appropriate. In light of the above, the request for right shoulder diagnostic arthroscopy, subacromial decompression, rotator cuff repair, lateral claviculectomy, possible synovectomy and labral repair is supported by guidelines and as such, the medical necessity of the request is substantiated.

14 day rental of cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Cold Therapy Unit

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: Continuous-flow cryotherapy.

Decision rationale: The California MTUS guidelines do not address this issue. The ODG guidelines are therefore used. Continuous-flow cryotherapy is recommended as an option for postoperative use after shoulder arthroscopy. It is generally used for 7 days. It reduces pain, swelling, inflammation and the need for narcotic medication in the postoperative period. The 14 day rental as requested exceeds the guidelines and as such, the medical necessity of the request is not substantiated.