

Case Number:	CM15-0007925		
Date Assigned:	01/29/2015	Date of Injury:	08/24/2012
Decision Date:	03/25/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/14/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 67-year-old male, who sustained an industrial injury on 08/24/12. Past surgical history was positive for right shoulder rotator cuff repair on 3/15/13, and right shoulder arthroscopic biceps tenodesis and tenotomy, multi-compartment synovectomy and debridement, lysis of adhesions, and subacromial decompression on 10/1/14. The 11/3/14 treating physician report cited continued right biceps soreness, slowing improving with physical therapy. Left shoulder pain was reported increased. Physical exam documented left shoulder range of motion 160/20/T12, right shoulder range of motion 165/30/T12, 4/5 bilateral extension and abduction strength, and positive crepitus with left shoulder range of motion. The patient was to finish right shoulder physical therapy. MRI of the left shoulder was requested. The 11/25/14 left shoulder MRI documented a full thickness tear of the supraspinatus tendon with retraction, and a large amount of joint effusion. Findings were suspicious for a chronic tear of the labrum, superiorly and inferiorly. There were mild degenerative changes of the acromioclavicular (AC) joint. The 12/15/14 treating physician report cited continued left shoulder pain. Physical exam was unchanged. The treatment plan included left total shoulder replacement with rotator cuff repair, pre-operative visit, ultra-sling, and post-op physical therapy. On 12/23/14, Utilization Review non-certified requests for subacromial decompression, pre-op medical clearance, left total shoulder arthroplasty, open rotator cuff repair, ultra-sling for the left shoulder and post-operative physical therapy 2 x6 for the left shoulder, noting that there was no evidence of failed conservative care with therapy, medications and injections for a three month period. As the

surgical procedures were not medically necessary, the associated surgical services were not medically necessary. The MTUS, ACOEM guidelines, or ODG was cited.

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: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Shoulder: 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. This patient presents with recently increased left shoulder pain. There is imaging evidence of a full thickness rotator cuff tear with retraction. There is no imaging evidence of significant glenohumeral or AC joint osteoarthritis. Clinical exam findings documented a fairly symmetrical shoulder presentation. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the left shoulder and failure has not been submitted. Therefore, this request is not medically necessary.

Pre-op 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 Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

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

Left total shoulder arthroplasty; open rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Shoulder: Arthroplasty (shoulder); Surgery for rotator cuff repair

Decision rationale: The California MTUS does not provide recommendations for total shoulder arthroplasty. The Official Disability Guidelines recommend shoulder arthroplasty for selected patients. Surgical indications include glenohumeral or acromioclavicular joint osteoarthritis with severe pain preventing a good night's sleep or functional disability that interferes with activities of daily living or work, positive radiographic findings of shoulder joint degeneration, and failure of at least 6 months of conservative treatment. The California MTUS guidelines provide general recommendations for rotator cuff repair and impingement syndrome. For rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for three months. Guideline criteria have not been met. This patient presents with recently increased left shoulder pain. There is imaging evidence of a full thickness rotator cuff tear with retraction. There is no imaging evidence of significant glenohumeral or AC joint osteoarthritis. Clinical exam findings documented a fairly symmetrical shoulder presentation. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the left shoulder and failure has not been submitted. Therefore, this request is not medically necessary.

Associated surgical service: Ultra sling for left shoulder: 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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213. Decision based on Non-MTUS Citation Shoulder, Postoperative abduction pillow sling

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

Post-op physical therapy 2 x 6 for left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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