

Case Number:	CM15-0016669		
Date Assigned:	03/10/2015	Date of Injury:	08/22/2013
Decision Date:	05/01/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/29/2015

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: Minnesota, Florida
 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 50-year-old male with a history of left shoulder pain. He weighs 230 pounds and his body mass index is 33. The primary treating physician's progress report dated 12/8/2014 indicates a date of injury of 8/22/2012-11/11/2013. The injured worker continued to have left shoulder pain rated 9/10 without medications. He had undergone arthroscopy of the left shoulder with subacromial decompression, Mumford procedure, and biceps tenodesis in January 2014. He had developed arthrofibrosis postoperatively and his shoulder continued to be painful. On examination flexion of the left shoulder was 105°, abduction 89°, extension 30°, adduction 50°, internal rotation 90° and external rotation 45°. An MRI scan of the left shoulder dated 5/19/2014 revealed postsurgical changes of the acromioclavicular joint, biceps tenodesis, moderate rotator cuff tendinosis, degeneration/tear of the superior anterior and posterior labrum, and small glenohumeral effusion. On 8/12/2014, x-rays of the left shoulder revealed a normal glenohumeral joint. An MR arthrogram of the left shoulder dated 9/5/2014 was reported to show a tear involving the anteroinferior glenoid labrum, which extended into the inferior aspect of the labrum. There was supraspinatus tendinopathy but no tear. There was evidence of biceps tenodesis and surgical decompression of the acromioclavicular joint. The assessment was left shoulder impingement syndrome and acromioclavicular joint degenerative joint disease status post arthroscopy; Postoperative arthrofibrosis and pain, left shoulder, and acromioclavicular arthritis of the right shoulder. The most recent progress report is dated 3/11/2015. Palpation of the left shoulder revealed no pain or tenderness and no swelling. Supraspinatus strength was 5/5, infraspinatus 5/5, deltoid 5/5 and subscapularis 5/5. Flexion of both shoulders was 170°, external

rotation 90° and internal rotation 50°. Abduction of the left shoulder was 170°, similar to the right shoulder. Instability testing was negative on the left. Impingement testing was positive on the right and negative on the left. Yergason's and Speed's testing was negative on the left. On December 31, 2014, Utilization Review non-certified a request for EKG, CBC, CMP, left shoulder A/S with anterior labral repair, Possible SAD, Possible rotator cuff repair, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On January 28, 2015, the injured worker submitted an application for IMR for review of requested EKG, CBC, CMP, left shoulder A/S with anterior labral repair, Possible SAD, Possible rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder A/S with Anterior Labral Repair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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, Labrum Tear Surgery.

Decision rationale: The injured worker has a tear of the anteroinferior labrum extending into the inferior labrum best seen on the MR arthrogram of 9/5/2014. This is usually associated with instability. ODG guidelines indicate a Bankart tear makes the shoulder more prone to recurrent dislocations. However, there is no evidence of instability documented. Examination did not reveal a positive apprehension sign or any evidence of instability. As such, repair of this tear is not recommended and the medical necessity has not been substantiated.

Possible Subacromial Decompression: Upheld

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

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

Decision rationale: California MTUS guidelines indicate that surgery for impingement syndrome is usually arthroscopic decompression. The procedure is not indicated for patients with mild symptoms are those with no activity limitations. Conservative care, including cortisone injections can be carried out for at least 3-6 months before considering surgery. An exercise rehabilitation program with physical therapy and home exercises are suggested along with 2-3 corticosteroid injections prior to consideration for surgery. The injured worker had undergone subacromial decompression in the past. The documentation indicates no evidence of impingement on the last physical examination. As such, the request for subacromial decompression is not supported and the medical necessity of the request has not been substantiated.

Possible Rotator Cuff Repair: Upheld

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

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

Decision rationale: California MTUS guidelines indicate rotator cuff repair for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. The MRI scan did not show any evidence of a rotator cuff tear. The MR arthrogram also did not show any evidence of rotator cuff tear. There is no documentation of a lesion that is known to benefit, in both the short and long-term from a surgical repair. As such, the medical necessity of a rotator cuff repair has not been substantiated.

Associated Surgical Service: CBC and CMP: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: Since the primary surgical procedure is not medically necessary, all of the associated services are not medically necessary.

Associated Surgical Service: EKG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: Since the primary surgical procedure is not medically necessary, all of the associated services are not medically necessary.