

Case Number:	CM15-0019844		
Date Assigned:	02/09/2015	Date of Injury:	05/29/2013
Decision Date:	05/01/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	02/02/2015

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 54-year-old male who sustained an industrial injury on 5/29/13. Injury occurred when he reached to pick up a 50-pound tool box from the floor. He was diagnosed with biceps tendon disruption and underwent right shoulder arthroscopy with labral debridement, intraarticular biceps tendon debridement, and mini-open biceps tenodesis. Residual pain was reported over the acromioclavicular (AC) joint and with overhead forceful work. Records documented a right shoulder subacromial injection on 9/4/14 and treatment with anti-inflammatory and pain medications. The 11/28/14 medical legal report physical exam documented tenderness over the anterior shoulder, subacromial region, and AC joint, with muscle spasms, trigger points, and crepitus. Shoulder range of motion testing documented flexion 160, abduction 150, external rotation 50, internal rotation 60, and adduction 30 degrees. Impingement and adduction tests were mildly positive. There was a painful arc of motion and 4+/5 shoulder strength. The 12/7/14 right shoulder MRI impression documented rotator cuff tendinopathy with interstitial splitting in the supraspinatus and infraspinatus tendons and mild subacromial bursitis but no cuff tear deficit or gap, or bursal distention. There was a chronic posterosuperior labral tear. The AC joint was degenerated and moderately hypertrophied. The AC joint slightly depressed the musculotendinous junction of the rotator cuff. The acromion was type II without downsloping or significant lateral spur. The 12/19/14 treating physician report cited continued diffuse right shoulder pain. Physical exam documented tenderness over the AC joint and greater tuberosity, and abduction to 165 degrees with marked discomfort. The recent MRI showed some fraying, but no rotator cuff tear. There was osteoarthritis of the AC joint and

some labral abnormalities. The treatment plan recommended right shoulder arthroscopy with probable subacromial decompression, possible rotator cuff repair and distal claviclectomy. The 1/8/15 utilization review modified the request for right shoulder arthroscopic decompression with acromioplasty, distal claviclectomy and possible rotator cuff repair to right shoulder arthroscopic distal claviclectomy, decompression with acromioplasty. The rationale stated that there was limited evidence of a rotator cuff tear to support the requested procedure. The request for a post-operative sling with bolster was modified to a post-operative sling without bolster as guidelines did not support pillow slings unless there was a large and massive rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopy distal claviclectomy right shoulder, decompression with acromioplasty, rotator cuff repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214, 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Shoulder Procedure Summary, ODG Indications for Surgery- Rotator Cuff repair, Acromioplasty, Partial Claviclectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for impingement syndrome; Surgery for rotator cuff repair; Partial claviclectomy.

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. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines (ODG) 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, positive impingement sign with a positive diagnostic injection test, and imaging evidence of impingement. The ODG for rotator cuff repair of partial thickness tears require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, positive diagnostic injection, and imaging findings of AC joint pathology. The 1/8/15 utilization review modified the request for right shoulder arthroscopic decompression with acromioplasty, distal claviclectomy and possible rotator cuff repair to right shoulder arthroscopic distal claviclectomy, decompression with acromioplasty. The request for possible rotator cuff repair was non-certified as there was no imaging evidence of a rotator cuff tear. The patient presents with signs/symptoms and clinical exam findings that are consistent with plausible rotator cuff pathology. A request for possible rotator cuff repair is reasonable based on these clinical indications as incomplete and MRI-

negative rotator cuff tears are often confirmed at the time of arthroscopic surgery. Therefore, this request is medically necessary.

Post-operative Shoulder sling (bolster): 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) TWC Shoulder Procedure.

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

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines recommend abduction slings as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. This patient is scheduled for a possible arthroscopic rotator cuff repair. He does not have a large or massive rotator cuff tear. A standard sling was certified in utilization review on 1/8/15; there is no compelling reason to support the medically necessary of a sling with a bolster pillow. Therefore, this request is not medically necessary.