

Case Number:	CM15-0145444		
Date Assigned:	08/06/2015	Date of Injury:	12/11/2014
Decision Date:	09/15/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/27/2015

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: Montana, Oregon, Idaho
 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 49-year-old male, who sustained an industrial injury on 12-11-2014, secondary to balancing helicopter blades resulting in pain shoulder and elbow. On provider visit dated 06-03-2015 the injured worker has reported left shoulder pain and dysfunction. On examination the left shoulder revealed tenderness at the anterior acromial margin and AC joint. Range of motion was noted as decreased. Positive Speed's impingement sign was noted. The diagnoses have included left shoulder pain and dysfunction, left shoulder impingement, left shoulder AC joint arthrosis and left shoulder partial thickness rotator cuff tear. Treatment to date has included injections, medications and physical therapy. The injured worker underwent a MRI of the left shoulder on 04-16-2015, which revealed acromioclavicular osteoarthritis, supraspinatus tendinosis and infraspinatus tendinosis. The provider requested left shoulder arthroscopy with subacromial decompression, debridement versus repair of the rotator cuff, two (2) week rental postoperatively of polar care unit, eighteen (18) sessions of post-operative physical therapy, 3 per week for 6 weeks to the left shoulder and purchase of sling and abduction pillow for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy with subacrominal decompression, debridement versus repair of the rotator cuff: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. An MRI from 4/6/15 demonstrated acromioclavicular osteoarthritis and tendinosis of the supraspinatus and infraspinatus without evidence of rotator cuff tear. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 6/30/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case, the exam note from 6/30/15 does not demonstrate evidence satisfying the above criteria. Therefore, the requested surgical procedure is not medically necessary.

Two (2) week rental postoperatively of polar care 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 (ODG), Shoulder-Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case, the request exceeds the guidelines recommendation of 7 days. Therefore, the request is not medically necessary.

Eighteen (18) sessions of post-operative physical therapy, 3 per week for 6 weeks to the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of postsurgical treatment visits allowable are: Rotator cuff syndrome/Impingement syndrome. (ICD9 726. 1; 726. 12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks. Postsurgical physical medicine treatment period: 6 months. The guidelines recommend initial course of therapy to mean one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in the guidelines. In this case, as the requested

surgical procedure is not medically necessary and the request exceed the recommended number of therapy sessions. Therefore the request is not medically necessary.

Purchase of sling and abduction pillow for the 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 (ODG), Shoulder- Postoperative abduction pillow sling.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

Decision rationale: CA MTUS/ACOEM is silent on the issue of abduction pillow. Per the ODG criteria, abduction pillow is recommended following open repair of large rotator cuff tears but not for arthroscopic repairs. In this case, there is no indication for need for open rotator cuff repair and the requested surgical procedure is not medically necessary. Therefore, none of the associated services are medically necessary and appropriate.