

Case Number:	CM15-0189853		
Date Assigned:	10/02/2015	Date of Injury:	03/11/2015
Decision Date:	12/14/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/28/2015

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: California, Indiana, Oregon
 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 female, who sustained an industrial injury on 3-11-15. She reported pain to the neck and left shoulder. The injured worker was diagnosed as having left shoulder strain or sprain and partial rotator cuff tear with impingement syndrome. Treatment to date has included at least 6 physical therapy visits and medication including Topamax and Tylenol. On 7-27-15 the treating physician noted the patient has difficulty with combing hair, bathing, dressing oneself, cooking, and making meals. The patient has difficulty with house work and difficulty with driving and turning the steering wheel. On 7-27-15 physical examination findings included decreased left shoulder range of motion with pain at end range of motion. Tenderness was noted to the left greater tuberosity, suprasternal notch, bicipital groove, scapula, and vertebral border of the scapula on the left. Subacromial grinding and clicking on the left was noted. No tenderness of the rotator cuff muscles was noted. Impingement and apprehension tests were positive on the left. A MRI of the left shoulder obtained on 4-29-15 revealed a partial tear along the posterior aspect of the supraspinatus tendon, supraspinatus tendinopathy, mild to moderate hypertrophy of the acromioclavicular joint, probable sublabral recess rather than a SLAP tear, and mild to moderate glenohumeral joint effusion. A few small degenerative subchondral cysts within the humeral head were also noted. On 7-27-15, the injured worker complained of intermittent left shoulder pain rated as 4-5 of 10. On 8-14-15 the treating physician requested authorization for arthroscopic surgery with subacromial decompression for the left shoulder, repair of all structures as needed in the left shoulder, possible open rotator cuff repair of the left shoulder, excision to AC joint of the left shoulder, pro-sling with abduction

pillow x1, hot-cold contrast unit, and postoperative physical therapy for the left shoulder x12. On 8-28-15 the requests were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic surgery with subacromial decompressions, left shoulder QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. 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 records do not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the request does not adhere to guideline recommendations and is not medically necessary.

Repair of all structures as needed, left shoulder QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. 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 records do not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the request does not adhere to guideline recommendations and is not medically necessary.

Possible open rotator repair, left shoulder QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the imaging does not demonstrate full thickness rotator cuff tear. The request is not medically necessary.

Excision to AC joint, left shoulder QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: Based upon the CA MTUS Shoulder Chapter, pages 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case the imaging does not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the request is not medically necessary.

Pro-sling with abduction pillow, left shoulder QTY: 1.00: 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 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 therefore request is not medically necessary.

Hot/cold contrast unit, left shoulder QTY: 1.00: 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 Official Disability Guidelines (ODG) Knee.

Decision rationale: CA MTUS/ACOEM is silent on the issue of hot/cold therapy. According to ODG, Knee and Leg section, cold/heat packs, hot packs had no beneficial effect on edema compared with placebo or cold application. Based on this the request for contrast unit is not medically necessary.

Postoperative physical therapy, 2 times weekly, left shoulder QTY: 12.00: 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 Official Disability Guidelines (ODG) Shoulder.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.