

Case Number:	CM15-0039784		
Date Assigned:	03/10/2015	Date of Injury:	07/17/2014
Decision Date:	04/23/2015	UR Denial Date:	02/16/2015
Priority:	Standard	Application Received:	03/02/2015

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: 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 61 year old male, who sustained an industrial injury on 07/17/2014. He has reported right shoulder and right wrist pain. The diagnoses have included right shoulder rotator cuff sprain and strain; right shoulder full-thickness rotator cuff tear; and right carpal tunnel and cubital tunnel syndrome. Treatment to date has included medications, wrist splint, MRI of the right shoulder, right shoulder x-rays, right wrist x-rays, and physical therapy. Medications have included Naprosyn. A progress note from the treating physician, dated 02/02/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of pain in the right shoulder and wrist; difficulty lifting the arm and has weakness; and numbness and tingling in the right hand. Objective findings included mild supraspinatus muscle atrophy of the right shoulder; forward flexion limited by pain; and positive Hawkins/Neer impingement sign. The treatment plan has included surgical repair due to the right shoulder full thickness rotator cuff tear. Request is being made for Outpatient diagnostic right shoulder arthroscopy with possible rotator cuff repair, biceps tenotomy versus tenodesis, labral repair, subacromial decompression, and distal clavicle excision; Pre-operative EKG, CBC, and Chem-14; Post-operative physical therapy 3 times a week for 4 weeks; and Durable medical equipment (DME) shoulder abduction pillow sling.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient diagnostic right shoulder arthroscopy with possible rotator cuff repair, biceps tenotomy versus tenodesis, labral repair, subacromial decompression, and distal clavicle excision: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Diagnostic arthroscopy, Biceps tenodesis, Criteria for partial claviclectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 210, 211, and 213. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Diagnostic arthroscopy, Biceps tenodesis, Lateral claviclectomy.

Decision rationale: With regard to the request for diagnostic arthroscopy, ODG guidelines indicate most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. In this case imaging is not inconclusive. There is evidence of a small full-thickness rotator cuff tear. There is also evidence of acromioclavicular arthritis. Therefore diagnostic arthroscopy is not supported by guidelines. With regard to the request for a rotator cuff repair, the California MTUS guidelines indicate for small full-thickness tears surgery is reserved for cases failing conservative therapy for 3 months. 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears are recommended. The documentation submitted does not indicate a trial and failure of such a conservative treatment program. As such, the guidelines do not recommend surgery at this time. With regard to the request for lateral claviclectomy, ODG guidelines indicate the criteria for partial claviclectomy include at least 6 weeks of conservative care plus subjective clinical findings of pain at the acromioclavicular joint, aggravation of pain with shoulder motion or carrying weight plus objective clinical findings of tenderness over the acromioclavicular joint and/or pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial plus imaging clinical findings of severe degenerative joint disease of the acromioclavicular joint. The documentation submitted does not include evidence of specific conservative treatment for the shoulder and confirmation of the pain source with injections of local anesthetics. With regard to the request for a biceps tenodesis ODG guidelines recommend biceps tenodesis as an option for type II or type IV SLAP lesions in patients over 40 years of age. The criteria include 3 months of conservative treatment and patients undergoing, concomitant rotator cuff repair. The MRI findings do not confirm presence of a SLAP lesion. As such, the request for biceps tenotomy or tenodesis or labral repair is not supported. In light of the above, the surgical request for diagnostic arthroscopy, rotator cuff repair, subacromial decompression, partial claviclectomy, labral repair, and biceps tenotomy vs tenodesis is not supported by guidelines at this time. As such, the medical necessity of the request has not been substantiated.

Pre-operative EKG, CBC, and Chem-14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 210, 211, and 213.

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

Post-operative physical therapy 3 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 210, 211, and 213.

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

Durable medical equipment (DME) shoulder abduction pillow sling: 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 Chapter, Postoperative abduction pillow sling.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 210, 211, and 213.

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