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| Case Number: | CM15-0039869 | | |
| Date Assigned: | 03/10/2015 | Date of Injury: | 01/03/2012 |
| Decision Date: | 04/14/2015 | UR Denial Date: | 02/18/2015 |
| Priority: | Standard | Application Received: | 03/03/2015 |

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 46-year-old male who sustained an industrial injury on 1/3/12. Injury occurred when a pry bar he was using gave way. He was diagnosed with a right rotator cuff tear and underwent right shoulder arthroscopic rotator cuff repair. The 1/9/14 left shoulder MRI impression documented bursal sided partial tear at the distal insertion of the supraspinatus tendon with an extended tear towards the musculotendinous junction. There were mild hypertrophic changes at the acromioclavicular (AC) joint. The long head of the biceps tendon was intact and the glenoid labrum was intact. The 11/3/14 left shoulder x-rays showed inferior AC osteophytes that impinged on the rotator cuff outlet. Conservative treatment was noted to include activity modification and medications. The 2/9/15 treating physician report cited left shoulder pain, especially at night. He was doing modified work because increased lifting, pushing and pulling causes his shoulder to hurt more. Left shoulder MRI showed evidence of supraspinatus impingement, probable tear of the superior glenoid labrum with bicipital tendinitis, and degenerative osteophyte detritus of the AC joint. Physical exam documented flexion to 160 degrees, abduction to 110 degrees, 4/5 flexion strength, 3/5 abduction strength, and positive impingement test. There was tenderness over the anterior bicipital groove and AC joint. The diagnosis included shoulder osteoarthritis, pain, impingement, long head biceps tendonitis, rotator cuff strain, and SLAP lesion. Left shoulder surgery was recommended. Authorization for left shoulder arthroscopy with probable debridement torn glenoid labrum, probable release long tendon biceps, open subacromial decompression with distal clavicle resection, and open acromioplasty with possible rotator cuff repair was requested. The 2/18/15 utilization review

non-certified the request for left shoulder surgery. The rationale for non-certification indicated that imaging did not demonstrate a labral tear, disruption of the biceps tendon, or a downsloping acromion to support the surgical request, and there was no evidence of physical therapy and injection therapy for the left shoulder. The associated surgical requests were also non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left sholder arthroscopy with probable debridement torn glenoid labrum and probable release long tendon bicep and open subacromial decompression with distal clavicle excision and open acromioplasty with possible rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Partial claviclectomy, Rotator cuff repair.

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 SLAP tear; Surgery for impingement syndrome; Surgery for rotator cuff repair.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months, including injections. The Official Disability Guidelines provide more specific indications for impingement syndrome 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 showing positive evidence of impingement are required. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have not been met. This patient presents with left shoulder pain. Clinical exam findings are consistent with imaging evidence of rotator cuff tear and plausible impingement. Guidelines state that diagnostic arthroscopy is the definite diagnosis of SLAP tears, and occult biceps tears, incomplete and MRI-negative are often confirmed at the time of arthroscopic surgery. However, detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial to the left shoulder, including injection, and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Surgical assistant: 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) Low Back, Surgical assistant.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

12 post-operative physical therapy treatments: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.