

Case Number:	CM15-0042679		
Date Assigned:	03/12/2015	Date of Injury:	12/14/2012
Decision Date:	04/17/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/05/2015

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 58-year-old female with a date of injury of 12/14/12, due to repetitive job duties. She underwent left shoulder arthroscopic surgery with subacromial decompression, partial acromioplasty, biceps tenodesis, and debridement of the glenohumeral joint on 6/19/13. She developed adhesive capsulitis and underwent manipulation under anesthesia on 11/12/13. The injured worker had reportedly failed to see improvement with physical therapy, injections, and acupuncture. Records indicated that the left shoulder had reached maximum medical improvement on 7/10/14. The injured worker reported a flare-up on 12/30/14 with inability to perform home exercise, and symptoms of depression, anxiety and stress with a request noted for psychological consult. Physical therapy was requested 2x4. The 1/21/15 left shoulder MR arthrogram impression documented a limited exam due to motion artifact blurring many images. The superior labrum was not visualized, abnormal. The biceps tendon was poorly seen, likely abnormal. The inferior labral elements and acromioclavicular (AC) joint were unremarkable. The findings indicated that there was adequate clearance between the undersurface of the acromion and superior aspect of the humeral head with unlikely impingement. The rotator cuff, musculotendinous portions of the supraspinatus, infraspinatus, subscapularis and teres minor were unremarkable. The 2/16/15 treating physician report cited bilateral shoulder pain, constant on the left and increased with movement. She had pain at night. Bilateral shoulder exam documented tenderness to palpation over the posterior greater than anterior aspect of the shoulder, and painful and limited range of motion in flexion, abduction and external rotation. Neer, Hawkins, and Jobe's tests were positive bilaterally. The treating

physician report indicated that the MRI showed a deep partial thickness tear of the supraspinatus tendon and extravasation of the fluid. She had just initiated physical therapy on 1/20/15 with 2 out of 8 visits completed. She had previously reportedly been at MMI then presented in Dec with flare up and had not completed treatment for the flare. PT was prescribed had done 2 at the time of surgical request. The treating physician requested left shoulder arthroscopy revision subacromial decompression and possible rotator cuff repair, pre-operative clearance as standard before surgery; post-operative physical therapy two times a week for six weeks; cold therapy unit for ten days to help with pain control and decrease the need for narcotic medication after surgery, and a sling. The 2/17/15 utilization review non-certified the request for left shoulder arthroscopy with revision subacromial decompression, possible rotator cuff repair with pre-operative clearance, post-op physical therapy 2x6, cold therapy unit for 10 days and a sling. The rationale for non-certification noted no clear documentation that conservative treatment had been exhausted.

IMR ISSUES, DECISIONS AND RATIONALES

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

One shoulder arthroscopy revision subacromial decompression and possible rotator cuff repair with pre op clearance: 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, Indications for surgery- Acromioplasty.

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 rotator cuff repair; Surgery for impingement syndrome and Other Medical Treatment Guidelines Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

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. 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. The Official Disability Guidelines provide more specific indications for impingement syndrome and rotator cuff repair 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, and positive impingement sign with a positive diagnostic injection test. For pre-operative clearance, evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have not been met. This patient presented in December 2014 with a flare-up of her left shoulder and inability to perform home exercise. An updated MR arthrogram was limited by motion

artifact with abnormalities of the superior labrum and biceps tendon noted. There was no imaging evidence of impingement. The treating physician opined a partial thickness rotator cuff tear. Physical therapy was initiated and the patient completed 2/8 visits. There are no detailed exam findings relative to range of motion or strength. Impingement tests are positive with no documentation of a diagnostic injection test. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including injection, and failure has not been submitted. As the surgical request is not supported, the request for pre-operative clearance is not supported. Therefore, this request is not medically necessary.

Associated service: post op physical therapy two times six: Upheld

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

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

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Cold therapy unit times 10 days, sling: Upheld

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

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: Continuous flow cryotherapy.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.