

Case Number:	CM15-0050707		
Date Assigned:	04/15/2015	Date of Injury:	06/29/2011
Decision Date:	06/02/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/17/2015

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

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 57-year-old female, who sustained an industrial injury on June 29, 2011. The injured worker reported continuous trauma injury to the left upper extremity. The injured worker was diagnosed as having status post left DEQ release, cervical spine sprain/strain with bilateral upper extremity radiculopathy, bilateral elbow medial/lateral epicondylitis, bilateral shoulder sprain, disorder of bursae and tendons in shoulder region, and carpal tunnel syndrome. Treatment to date has included shoulder ultrasound, one cortisone injection, home exercise program (HEP), and medication. Currently, the injured worker complains of left shoulder pain and right elbow pain. The injured worker presented on 12/19/2014, for an orthopedic consultation regarding the left shoulder. The injured worker had failed all attempts at aggressive conservative management and continued to report 9/10 pain. Upon examination of the left shoulder, there was 150-degree forward flexion, 40 degree extension, 145 degree abduction, 40 degree adduction, 90 degree external rotation, and 60 degree internal rotation. There was severe supraspinatus tenderness, moderate greater tuberosity tenderness, mild biceps tendon tenderness, moderate AC joint tenderness, subacromial crepitus, 4/5 motor weakness, positive AC joint compression test, positive impingement sign, and negative Speed and O'Brien's test. An ultrasound study of the left shoulder dated 05/08/2014 revealed AC joint degenerative disease, high-grade partial thickness rotator cuff tear, and subacromial fibrosis with adhesion formation/impingement syndrome. The physician recommended and arthroscopic evaluation of the left shoulder with subacromial decompression, distal clavicle resection, and rotator cuff debridement. A Request for Authorization form was then submitted on 12/19/2014. The

ultrasound report dated 05/08/2014, was provided for review, and confirmed bilateral AC joint hypertrophy, a high-grade partial thickness rotator cuff tear, and subacromial fibrosis/adhesions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic subacromial decompression, distal clavicle resection, rotator cuff debridement and/or repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: The CA MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. In this case, there is documentation of subjective and objective findings, including weak abduction, tenderness over the anterior acromial area, and positive impingement sign. There is documentation of a failure of 3 to 6 months of conservative treatment, including cortisone injections. The request was previously denied, as there was no documentation of the ultrasound imaging report identifying left shoulder pathology. However, in this case, the physician has provided the official imaging report dated 05/10/2014, which confirms bilateral AC joint hypertrophy with narrowing of the subacromial space, a high-grade partial thickness rotator cuff tear, and left subacromial fibrosis/adhesion formation. Given the above, the request can be determined as medial appropriate at this time.

Pre-op medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative testing, general.

Decision rationale: According to the Official Disability Guidelines, the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, there was no documentation of a significant medical history or any underlying comorbidities to support the necessity for preoperative medical clearance. Given the above, the request is not medically necessary.

Post-op physical therapy 3 x 4 for the left shoulder: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 26-27.

Decision rationale: The California MTUS Guidelines state the initial course of therapy means one-half of the number of visits specified in the general course of therapy for the specific surgery in the post-surgical physical medicine treatment recommendations. Postsurgical treatment for arthroscopic surgery for rotator cuff syndrome/impingement syndrome includes 24 visits over 14 weeks. The guidelines would support an initial 12 sessions of postoperative physical therapy. Given the above, the request for 12 sessions of postoperative physical therapy for the left shoulder can be determined as medically necessary in this case.

Associated surgical service: CPM device: 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 Chapter, Continuous passive motion.

Decision rationale: The Official Disability Guidelines recommend continuous passive motion as an option for adhesive capsulitis. Continuous passive motion is not recommended for shoulder rotator cuff problems. As such, the request cannot be determined as medically appropriate in this case. Therefore, the request is not medically necessary at this time.

Associated surgical service: Surgi-stim unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: The California MTUS Guidelines recommend postoperative transcutaneous electrotherapy as a treatment option for acute postoperative pain in the first 30 days following surgery. Rental is preferred over purchase during the 30-day trial. The request for a Surgi-stim unit purchase would exceed guideline recommendations. As such, the request is not medically necessary.

Associated surgical service: Cold therapy unit: 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 Chapter, Continuous passive motion.

Decision rationale: The Official Disability Guidelines recommend a continuous flow cryotherapy unit for up to 7 days following surgery. Although it is noted that the injured worker has been issued authorization for a left shoulder arthroscopic surgery, the request for a cold therapy unit purchase would exceed guideline recommendation. Given the above, the request is not medically necessary at this time.