

Case Number:	CM15-0065838		
Date Assigned:	04/13/2015	Date of Injury:	03/28/2013
Decision Date:	07/07/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/07/2015

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 55-year-old female who sustained an industrial injury on 3/28/13. Injury occurred while moving heavy cabinets at work. Past medical history was documented as negative. Past surgical history documented kidney surgery. The 3/20/14 right shoulder MRI impression documented tendinopathy or small intrasubstance tear of the distal supraspinatus tendon. There was infraspinatus tendinopathy with mild grade 1 interstitial tear at the infraspinatus myotendinous junction, and subacromial subdeltoid bursitis. There was right acromioclavicular (AC) joint osteoarthritis with lateral downsloping acromion and narrowing of the lateral subacromial outlet. The 8/25/14 right shoulder x-rays documented a type II acromion with an eyebrow sign and lateral downsloping, as well as AC joint arthritis. Conservative treatment had included physical therapy, 3 corticosteroid injection injections, activity modification, home exercise, and anti-inflammatory medications. The 3/10/15 treating physician report cited right shoulder pain in the lateral deltoid area, aggravated by abduction and overhead use. She had completed 6 more physical therapy sessions, including home exercises, with no overall improvement. Physical exam documented right shoulder range of motion 170/90/70 with pain, AC joint tenderness, positive impingement sign, negative O'Brien's, no biceps deformity, and no pain or weakness with abduction strength testing. The diagnosis was right rotator cuff impingement, AC joint arthrosis, and labral tear. Authorization was requested for a right shoulder arthroscopic acromioplasty, Mumford, possible labral repair, and possible rotator cuff repair, and 12 post operation physical therapy visits, cold therapy unit immobilizer, pre-op complete blood count/comprehensive metabolic profile (CBC/CMP), and Norco 7.5 mg. The 3/25/15 utilization review non-certified the right shoulder arthroscopic acromioplasty, Mumford, possible labral repair, and possible rotator cuff repair, and associated

surgical requests, as there was no evidence that conservative treatment had failed and no severe degenerative on imaging to warrant the Mumford procedure. The 3/29/15 treating physician appeal letter stated that the injured worker was 2 years status post injury and had undergone a course of physical therapy and 3 injections for her shoulder pain. She had undergone physical therapy from 4/29/13 to 6/27/13 and her symptoms did not resolve. She underwent 6 additional visits from 1/20/15 to 3/10/15 with persistent pain. Relative to the Mumford procedure, plain x-rays showed AC joint arthritis. The right shoulder MRI demonstrated osteoarthritis with joint space narrowing, osteophyte formation, and bone marrow edema of the distal clavicle. She localized her pain to the AC joint and her AC joint pain had been relieved by corticosteroid injection. She clearly met criteria for a Mumford procedure or AC joint resection. A diagnosis of severe AC joint degeneration was not required for surgical treatment. Appeal of the denial of this surgery was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) right shoulder acromioplasty, Mumford, possible labral repair possible rotator cuff repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

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) Surgery for rotator cuff repair; Acromioplasty; Surgery for impingement surgery; Partial claviclectomy.

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. The Official Disability Guidelines for impingement and rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment, plus painful arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, rotator cuff or anterior acromial tenderness, and positive impingement sign with a positive diagnostic injection test. Criteria include imaging evidence of a rotator cuff deficit. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have been met. The injured worker presents with persistent shoulder pain aggravated with abduction and overhead activity. Function difficulty in work and activities of daily living was noted. Clinical exam findings were consistent with imaging evidence of rotator cuff deficit, impingement syndrome, and AC osteoarthritis. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Twelve (12) post-operation physical therapy visits: Overturned

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

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for impingement syndrome suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.

One (1) cold therapy unit immobilizer: 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), Continuous-flow cryotherapy.

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: The California Medical Treatment Utilization Schedule generally support the short term use of a shoulder immobilizer in the post-operative period, but are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a post-op shoulder immobilizer is reasonable. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use of a cold therapy unit which is not consistent with guidelines. Therefore, this request is not medically necessary.

One (1) pre-op CBC/CMP: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Danielson D, Bjork K, Card R, Foreman J, Harper C, Roemer R, Stultz J, Sypura W, Thompson S, Webb B. Preoperative evaluation, Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2012 Jul. 61 p.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type

and invasiveness of the planned procedure. Guideline criteria have been met based on patient age, plausible long-term use of non-steroidal anti-inflammatory drugs, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

One (1) prescription of Norco 7.5mg #100: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212, Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-80, 91.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support the use of opioids on a short term basis for shoulder pain. Guidelines recommend Norco for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Short-acting opioids, also known as "normal-release" or "immediate-release" opioids, are seen as an effective method in controlling both acute and chronic pain. Guideline criteria have been met for the post-operative use of Norco. Therefore, this request is medically necessary.