

Case Number:	CM15-0087131		
Date Assigned:	05/11/2015	Date of Injury:	08/27/2013
Decision Date:	07/02/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	05/07/2015

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 56-year-old male who sustained an industrial injury on 8/27/13. Injury occurred when he reached to take papers out of a copier and felt his shoulder pop. Past surgical history was positive for left shoulder arthroscopy with rotator cuff repair on 11/7/13, and adhesive capsulitis release in April 2014. Following the surgery in April, records indicated that he had completed 3 physical therapy sessions. Conservative treatment included TENS unit, heat/cold, activity modification, oral medications, and topical creams. The 1/13/15 left shoulder MR arthrogram impression noted the injured worker was post supraspinatus tendon repair. The tendon distally was thinned but not perforated. Rotator cuff tendinosis was present. There were degenerative changes of the posterior labrum without a displaced tear. The humeral head was mildly subluxed posteriorly, correlate for posterior shoulder instability. The glenohumeral joint axillary pouch had a thinned appearance, likely from a past tear. There was discontinuity of the coracohumeral ligament. There was mild acromioclavicular joint osteoarthritis. The 3/18/15 treating physician report cited left shoulder and hand pain with shooting pain down the left arm with numbness and tingling. Left shoulder exam documented tenderness along the rotator cuff, acromioclavicular joint, and exquisite tenderness along the biceps tendon. He had 4/5 abduction strength, 5-/5 external rotation strength, and positive impingement, Hawkins's, cross arm, and Speed's tests. Range of motion testing documented abduction 140 degrees, external rotation 70 degrees, and internal rotation 60 degrees. The diagnosis included left shoulder impingement, rotator cuff strain, and bicipital tendinitis status post arthroscopy and rotator cuff repair in November 2013. There was an element of left ulnar neuritis and radicular symptoms from the neck and numbness and tingling. The treatment plan has included the request for

left shoulder operative arthroscopy with possible distal clavicle excision, bicep tendon release and stabilization, evaluation of rotator cuff; and associated surgical services: Polar care 21 day rental; immobilizer; and pre-operative clearance. The 3/31/15 utilization review non-certified the left shoulder operative arthroscopy with possible distal clavicle excision, bicep tendon release and stabilization, and evaluation of rotator cuff and associated surgical requests as there was no evidence of significantly limited range of motion, adequate trial of physical therapy, or clear evidence of rotator cuff tear, long head biceps tendon tear or tendinopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder operative arthroscopy with possible distal clavicle excision, bicep tendon release and stabilization, evaluation of rotator cuff: Upheld

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

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: Biceps tenodesis; 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 (ODG) criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, positive diagnostic injection, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. The ODG state that consideration of biceps tenodesis should include evidence of an incomplete tear with associated subjective/objective clinical findings. Guideline criteria have not been met. This injured worker presents with persistent left hand pain. Clinical exam findings are consistent with impingement syndrome, AC joint arthrosis, and biceps involvement. There is no evidence of adhesive capsulitis. There is imaging evidence of rotator cuff tendinosis, degenerative labral changes, and plausible instability. However, there is no detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There was minimal physical therapy provided following the last surgery. Therefore, this request is not medically necessary at this time.

Associated Surgical Service: Polar care 21 day rental: 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, Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous flow cryotherapy.

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

Associated Surgical Service: 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), Shoulder, Postoperative Abduction Pillow Sling.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints page(s): 205, 213.

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

Associated Surgical Service: Pre-op 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 (ODG), Low Back, Preoperative testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

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