

Case Number:	CM15-0089003		
Date Assigned:	05/13/2015	Date of Injury:	01/12/2010
Decision Date:	07/10/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/08/2015

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: Minnesota, Florida
 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 43 year old male, who sustained an industrial injury on January 12, 2010. He reported low back pain, left shoulder and elbow pain. The injured worker was diagnosed as having left shoulder pain, possible left rotator cuff tear, status post bicep tendon rupture of the left arm with repair and chronic flexor muscle weakness, osteomyelitis, chronic left elbow pain, chronic pain syndrome and myofascial pain. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention of the left upper extremity, conservative care, medications and work restrictions. Currently, the injured worker complains of continued low back, left shoulder and left elbow pain with associated tingling and numbness of the left upper extremity and hand with associated anxiety secondary to chronic pain. The injured worker reported an industrial injury in 2010, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on March 27, 2015, revealed continued pain as noted. A neurology consultation was recommended as soon as possible. Evaluation on April 15, 2015, revealed continued pain as noted with associated symptoms. The request for a neurology consultation was authorized. It was noted he started Lyrica on the previous visit and noted some improvement in neurological pain. He reported using pain medications with some relief. Pre-operative electrocardiogram and surgical clearance and left shoulder surgery with post-operative occupational therapy was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy, acromioplasty and joint debridement: 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 Chapter - Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 213.

Decision rationale: MRI scan of the left shoulder from 3/26/15 revealed an obliquely oriented tear of the supraspinatus tendon which was partial-thickness extending longitudinally without evidence of a full-thickness tear. This was superimposed on supraspinatus and infraspinatus tendinosis. There was some degeneration of the superior labrum. There was fraying of the posterior labrum which was partially replaced by a spur like distal anterior acromion noted on the lateral. Down sloping narrows the supraspinatus outlet with mild adjacent subacromial sub deltoid bursitis. Thickening of the axillary pouch with mild intermediate signal intensity seen within it which could be related to chronic capsulitis or capsular sprain. The diagnosis was left shoulder impingement syndrome with high-grade partial thickness supraspinatus tendon tear; status post distal biceps tendon repair with evidence of chronic infection treated with multiple I&D's and possible left cubital tunnel syndrome. Review of the office notes of that day indicates full range of motion in the left shoulder with full rotator cuff strength and a positive impingement sign. There was no tenderness over the acromioclavicular joint, no muscular atrophy, and no crepitus with shoulder motion. The plan as of 4/16/2015 was left shoulder arthroscopy, acromioplasty and joint debridement with possible rotator cuff repair; preoperative lab: Metabolic panel; preoperative EKG. The surgery request was noncertified by utilization review as there was no documentation of at least 3 months of conservative treatment with physical therapy and injections. The provider has indicated that the injured worker did receive physical therapy on 2 occasions, for 2 months after the elbow surgery and 3 months with cardiac rehabilitation, a total of 5 months; however, documentation of injections was not received. California MTUS guidelines indicate 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome or small tears. Conservative care including cortisone injections can be carried out for at least 3-6 months before considering surgery. The appeal was therefore denied on 5/6/2015. The procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Evidence of pain source localization with a subacromial injection of local anesthetic and evidence of corticosteroid injections combined with an exercise rehabilitation program will be necessary to comply with guideline recommendations. As such, in light of the foregoing the request for arthroscopy of the left shoulder with acromioplasty and debridement is not supported by guidelines and the medical necessity of the request has not been substantiated.

Possible rotator cuff repair: 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 Chapter - Indications for Surgery.

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

Decision rationale: With respect to the request for a possible rotator cuff repair, the guidelines recommend rotator cuff repairs for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. The imaging studies do not show a full thickness tear. The documentation does not indicate any weakness or limitation of motion on the recent examination. In light of the foregoing, the request for arthroscopy of the left shoulder with possible rotator cuff repair is not supported by guidelines and the medical necessity of the request has not been substantiated.

Associated surgical services: Pre-op lab: metabolic panel: 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): 210, 211, 213.

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

Associated surgical services: Pre-op EKG: 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): 210, 211, 213.

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

Associated surgical services: Post-op occupational therapy: 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): 210, 211, 213.

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