

Case Number:	CM15-0089806		
Date Assigned:	05/20/2015	Date of Injury:	10/09/2013
Decision Date:	07/08/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/11/2015

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 26-year-old male who sustained an industrial injury on 10/9/13. The mechanism of injury was not documented. Past surgical history was positive for left shoulder arthroscopic surgery with subacromial decompression and Mumford procedure on 4/1/14 with possible injury to the coracoclavicular ligament. The 3/20/15 left shoulder MRI impression documented mild edematous change noted at the subacromial subdeltoid bursa compatible with mild bursitis. There was no evidence suggestive of rotator cuff tear. The bony glenoid process and glenoid labral were unremarkable with no evidence of acute osteochondral fracture or loose body. There were slight hypertrophic changes noted at the acromioclavicular (AC) joint and slight lateral downsloping of the acromion abutting on the superior aspect of the supraspinatus tendon. There were a few small subcortical cysts noted in the humeral head, which may be secondary to physiologic internal impingement. Recent conservative treatment included modified duty, activity modification, anti-inflammatory medications, corticosteroid injection (11/5/14), and physical therapy. The 4/10/15 treating physician report cited increasing left shoulder pain. Any type of lifting, pulling, or pushing caused extensive shoulder pain. He was not lifting more than 10 pounds. The MRI showed hypertrophic changes of the acromioclavicular joint with lateral downsloping of the acromion abutting the superior aspect of the supraspinatus tendon. Physical exam documented AC and subacromial tenderness, decreased range of motion, positive Neer sign, positive thumbs down test, and global left shoulder weakness. The diagnosis included recurrent left shoulder impingement syndrome with downsloping of the acromion and hypertrophic AC joint changes. Functional limitations were

reported in heavy lifting and overhead activities hindering work and activities of daily living. He had failed conservative treatment with medications providing temporary relief. Authorization was requested for an arthroscopic examination/revision subacromial decompression/revision of Mumford procedure, medical clearance, sling for the left shoulder, ten-day rental of a cold therapy unit, and post-operative physical therapy one time a week for twelve weeks for the left shoulder. The 4/29/15 utilization review non-certified the request for left shoulder arthroscopic examination/revision subacromial decompression/revision of Mumford procedure and associated surgical requests as there was no documentation of a corticosteroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Examination, Revision Subacromial Decompression, revision Mumford Procedure: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder online version, Partial claviclectomy (Mumford procedure).

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 Impingement syndrome.

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. The Official Disability Guidelines provide more specific indications for impingement syndrome 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, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. Guideline criteria have been met. This injured worker presents with persistent left shoulder pain. Functional limitations are noted in work and activities of daily living. Clinical exam findings are consistent with imaging evidence of impingement. 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.

Associated Surgical Service: Medical Clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Healthcare protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2014 Mar. 124p. <http://www.guideline.gov/content.aspx?id=48408>.

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: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on long-term use of non-steroidal anti-inflammatory drugs and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Associated Surgical Service: Sling for the Left Shoulder: Overturned

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: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.

Associated Surgical Service: Cold Therapy Unit (10-day rental): Overturned

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: Continuous-flow cryotherapy.

Decision rationale: The California MTUS 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. This request for cold therapy unit slightly exceeds guideline recommendations but is reasonable for post-operative pain management. Therefore, this request is medically necessary.

Post-Operative Physical Therapy for the Left Shoulder (12-sessions, once a week for 12 weeks): Overturned

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

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 request for physical therapy is consistent with guideline recommendations for initial post-operative treatment. Therefore, this request is medically necessary.