MAXIMUS Federal Services

Case Number:	CM14-0019425		
Date Assigned:	02/21/2014	Date of Injury:	02/03/2012
Decision Date:	07/24/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/15/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 43-year-old male who has filed a claim for shoulder/arm sprain associated with an industrial injury date of February 03, 2012. Review of progress notes indicates bilateral shoulder and neck pain, with bilateral upper extremity numbness. Findings include tenderness of the cervical and thoracic regions; positive Spurling's extension test and lateral bending test; decreased cervical and right shoulder range of motion with positive provocative tests including Neer's, Hawkin's, cross chest adduction, Yergason's, and Speed's test; and slightly decreased motor strength of the supraspinatus. Right shoulder MRI dated April 04, 2012 showed full thickness tear of supraspinatus tendon with marked tendinopathy, tendinopathy of the biceps tendon at the rotator cuff interval, and possible small SLAP tear. Treatment to date has included NSAIDs, opioids, hot and cold compresses, bilateral subacromial corticosteroid injections, and physical therapy. Patient had 40% improvement of right shoulder pain and increased strength. Utilization review from January 28, 2014 denied the requests for right shoulder arthroscopic rotator cuff repair as there was improvement with subacromial corticosteroid injections and physical therapy, and cervical spine pathology has not been ruled out; acromioplasty including Mumford procedure as MRI did not show pathology to meet the criteria; SLAP debridement as the MRI findings did not meet criteria for repair; open biceps tenodesis as surgery is not necessary for function; and post-op physical therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPIC ROTATOR CUFF REPAIR: Upheld

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

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, Surgery for rotator cuff repair.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, surgery for rotator cuff repair is indicated in patients with diagnosed full thickness rotator cuff tear, and cervical pathology and frozen shoulder syndrome have been ruled out; shoulder pain and inability to elevate the arm; weakness with abduction; and imaging showing evidence of deficit in rotator cuff. In this case, patient has a right shoulder MRI showing full thickness tear of the supraspinatus tendon. However, the patient also complains of neck pain with bilateral upper extremity symptoms, and cervical pathology cannot be ruled out. Also, there is no documentation of inability to elevate the arm; motor strength testing was 4+/5 for the supraspinatus. Therefore, the request for right shoulder arthroscopic rotator cuff repair was not medically necessary.

POST-OP PHYSICAL THERAPY (UNKNOWN QUANTITY): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

ACROMIOPLASTY: 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, Surgery for impingement syndrome.

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, Surgery for impingement syndrome.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. Criteria for arthroscopic decompression (acromioplasty) include 3-6 months of conservative care; subjective findings - pain with active arc motion at 90-130 degrees and pain at night; objective findings - weak or absent abduction or atrophy, tenderness over rotator cuff or anterior acromial area, and positive impingement sign with

temporary relief with anesthetic injection; and positive imaging findings of impingement. In this case, there is no documentation of pain with active motion at 90-10 degrees or pain at night, weak to absent abduction or muscle atrophy, or MRI findings of impingement. Therefore, the request for acromioplasty was not medically necessary.

MUMFORD PROCEDURE: 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, Partial claviculectomy.

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, Partial claviculectomy (Mumford procedure).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, indications for partial claviculectomy (includes Mumford procedure) includes at least 6 weeks of conservative care; subjective findings of pain at AC joint, aggravation of pain with shoulder motion or carrying weight, or previous grade I or II AC separation; objective findings of tenderness over the AC joint and/or pain relief obtained with an injection; and imaging findings showing post-traumatic changes of AC joint, severe DJD of AC joint, or complete/incomplete separation of AC joint, with positive bone scan for AC joint separation. In this case, the right shoulder MRI did not show findings consistent with AC joint pathology as mentioned above; the MRI showed minimal degenerative changes of the AC joint. Therefore, the request for Mumford procedure was not medically necessary.

SLAP 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 (Acute & Chronic), SLAP lesion diagnosis.

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, SLAP lesion diagnosis.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, type I SLAP lesions (fraying and degeneration of the superior labrum, with normal biceps) are the most common type of SLAP tear, and may be treated with debridement. In this case, the patient's right shoulder MRI showed a focal area of intermediate signal at the anterior superior labrum, with possibility of a small SLAP tear. The criteria for SLAP debridement as outlined above have not been met. Therefore, the request for SLAP debridement was not medically necessary.

OPEN BICEPS TENODESIS: Upheld

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

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, Surgery for ruptured biceps tendon (at the shoulder).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, criteria for tenodesis of long head of biceps with diagnosis of incomplete tear or fraying of the proximal biceps tendon includes subjective complaint of more than normal amount of pain that does not resolve with attempt to use arm, with pain and function failing to follow the normal course of recovery; and imaging findings showing evidence of deficit in rotator cuff. For complete tears of the proximal biceps tendon, criteria include pain, weakness, and deformity with classical appearance of ruptured muscle. Surgery is almost never considered in full thickness ruptures. For reinsertion of ruptured biceps tendon with distal rupture, repair should be within 2-3 weeks of injury or diagnosis. Surgery is not indicated if 3 or more months have elapsed. In this case, the imaging findings do not show incomplete tear or fraying of the biceps tendon to support this procedure. Therefore, the request for open biceps tenodesis was not medically necessary.