MAXIMUS Federal Services

Case Number:	CM14-0121983		
Date Assigned:	08/06/2014	Date of Injury:	01/14/2014
Decision Date:	09/19/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/01/2014

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 50 year old female who was injured on 01/14/2014 when she tripped over a carpet piece that was damaged. She landed on her chest and experienced immediate pain to her neck, right shoulder, right arm, right wrist/hand, and right knee. She has been treated with pain medications. Diagnostic studies reviewed include MRI of the right shoulder dated 03/27/2014 demonstrated complete tear of the supraspinatus tendon with 16 mm tendinous retraction; infraspinatus tendinitis; acromioclavicular osteoarthritis; joint effusion; bicipital tenosynovitis versus fluid tracking along the biceps tendon secondary to direct communication with the joint space. Progress report dated 06/23/2014 states the patient complained of right shoulder pain associated with throbbing that increases at nighttime. She also complains of weakness with use of the right shoulder. The pain spreads from the shoulder blade to the base of the neck on the right side. On exam, the right shoulder revealed tenderness to palpation in the subacromial space as well as in the acromioclavicular joint with markedly positive impingement sign as well as positive anterior cross-arm test. Biceps tendon test is negative. Apprehension test is negative; resisted abduction/external rotation of the right shoulders reveals weakness. There is a moderate limitation identified with range of motion of the right shoulder including abduction and internal rotation. Neurological exam revealed no motor weakness other than rotator cuff. She is diagnosed with impingement syndrome of the right shoulder associated with full thickness tear of the rotator cuff, supraspinatus and arthritic changes of the right acromioclavicular joint. The treatment and plan included right shoulder surgery with open decompression to include Mumford procedure for excision of the distal clavicle and rotator cuff repair. The request is also for post-operative physical therapy and rehab for the shoulder.Prior utilization review dated 07/22/2014 states the request for right shoulder open decompression and rotator cuff repair is denied as there is no evidence to support the request; therefore the remaining requests for Pre-operative medical

clearance to include labs, chest x-ray and EKG, DME: Shoulder Pulley, Physical therapy, 6 visits post-operatively are denied as the surgery is denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery right shoulder open decompression and rotator cuff repair.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for rotator cuff repair & Surgery for impingement syndrome.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 9 Shoulder Complaints, page 210-211 and on the Non-MTUS Official Disability Guidelines (ODG), Shoulder, Surgery for rotator cuff repair & Surgery for impingement syndrome.The Expert Reviewer's decision rationale:As per CA MTUS/ACOEM guidelines, "surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least three to six months before considering surgery." Further guidelines indicate that "Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers." In this case, this patient continues to complain of right shoulder pain, weakness, radiating to neck on right side as well as increased pain at nighttime. She had MRI of right shoulder that showed rotator cuff tear and AC osteoarthritis. On physical exam, there was positive impingement sign and anterior cross-arm test. There was weakness with abduction/external rotation of the right shoulder and moderate limitation of range of motion including abduction and internal rotation. She was diagnosed with impingement syndrome of the right shoulder associated with full thickness tear of the rotator cuff, supraspinatus and arthritic changes of the right acromioclavicular joint. Based on the records submitted for review, the request for right shoulder open decompression and rotator cuff repair is not medically necessary. As per the ACOEM and ODG guidelines, there should be an initial trial and failure of 3-6 months of conservative care including medications, physical therapy and injections. In this case, there is MRI evidence of rotator cuff tear and objective findings correlating with subjective complaints, but there is no documentation that this patient was treated with an initial trial of physical therapy and injections. Thus, the requested right shoulder is not medically necessary.

Pre-operative medical clearance to include labs, chest x-ray and EKG.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Preoperative testing.

Decision rationale: The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG), Low back, Preoperative testing.The Expert Reviewer's decision rationale:CA MTUS/ACOEM is silent the issue in dispute. Also, the ODG for shoulder chapter do not discuss the issue but ODG lower back chapter indicates the decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, this patient has a history of hypertension and diabetes and pre-operative tests are recommended; however, since the requested right shoulder surgery is considered not medically necessary and appropriate; the request for pre-operative medical clearance to include labs, chest x-ray and EKG is not medically necessary.

Assistant Surgeon.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG: Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:Co-Surgeon, Assistant Surgeon, Team Surgeon and Assistant-at-Surgery Guidelines.

Decision rationale: The Expert Reviewer based his/her decision on the Non-MTUS Other Medical Treatment Guideline or Medical Evidence: Co-Surgeon, Assistant Surgeon, Team Surgeon and Assistant-at-Surgery Guidelines. The Expert Reviewer's decision rationale:CA MTUS/ACOEM and ODG do not discuss about the request for assistant surgeon. The referenced guidelines indicate that assistant surgeon is recommended, but since the requested right shoulder surgery is considered not medically necessary and appropriate; the request for assistant surgeon is not medically necessary.

Physical therapy, 6 visits post-operatively.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG: Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical Therapy.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Postsurgical Treatment Guidelines, Rotator Cuff Repair, page 26-27 and on the Non-MTUS Official Disability Guidelines (ODG), Shoulder, Physical Therapy. The Expert Reviewer's decision rationale:CA MTUS/post-surgical treatment guidelines and ODG recommends up to 24 visits of postop physical therapy, but since the requested right shoulder surgery is considered not

medically necessary and appropriate; the request for physical therapy, 6 visits post-operatively is not medically necessary.

DME: Shoulder Pulley: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG: Shoulder Chapter.

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

Decision rationale: The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG), Shoulder, Physical Therapy.The Expert Reviewer's decision rationale:CA MTUS/ACOEM guidelines do not discuss about the shoulder pulley. ODG recommends use of a home pulley system for stretching and strengthening should be recommended. However, since the requested right shoulder surgery is considered not medically necessary and appropriate; the request for shoulder pulley is not medically necessary.