

Case Number:	CM14-0149016		
Date Assigned:	09/30/2014	Date of Injury:	05/28/2014
Decision Date:	01/08/2015	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/12/2014

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 Orthopaedic 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:

This 53-year-old male machine operator sustained an industrial injury on 5/28/14, due to cumulative trauma. Past medical history was positive for hypertension and hypercholesterolemia. Past surgical history was positive for right shoulder fracture surgery in 1968 and right heel surgery in 2005. Initial conservative treatment included x-rays that were found to be normal, and 6 visits of physical therapy without benefit. The 7/9/14 right shoulder MRI impression documented tear of the superior and anterosuperior portions of the right glenoid labrum, and mild right supraspinatus tendinosis with intact rotator cuff. There was moderately laterally downsloping orientation of the right acromion, which might increase the anatomic risk for subacromial impingement, and trace fluid in the subacromial/subdeltoid bursa, which may represent bursitis. The 8/8/14 treating physician progress report cited mild right shoulder pain associated with burning and stabbing in the biceps muscles, and popping and weakness of the right shoulder. Functional difficulty was noted in pushing, pulling, lifting, carrying, reaching overhead, reaching behind his back, and gripping/grasping. He was currently working with restrictions. Right shoulder exam documented anterior well-healed scar, anterior tenderness, and no visible muscle atrophy. Impingement, Neer's, Hawkin's, cross arm, arc sign, and drop arm tests were positive. He had clicking coming from the acromioclavicular joint. There was tenderness over the superior lateral aspect of the shoulder in the rotator cuff and pain with stressing of the supraspinatus and infraspinatus musculature. There was no erythema, ecchymosis, or swelling. Pain was reported with stressing the biceps tendon in positions suggestive of rotator cuff pathology. O'Brien's test was negative. There was some tingling noted in the right hand with negative Spurling's, Durkin's, and Tinel's tests. The diagnosis included right shoulder impingement syndrome, rotator cuff tendinitis, AC joint cartilage disorder, subacromial bursitis, and SLAP tear with negative O'Brien's test. The treatment plan

recommended one subacromial corticosteroid injection as both diagnostic and therapeutic and orthopedic views of the right shoulder to determine the exact downsloping of the acromion and outlet view to assess the supraspinatus tunnel. If the patient fails injection, he will need subacromial decompression surgery with debridement of the bursa, resection of the distal clavicle and possible excision of the coracoacromial ligament. After discussion with the patient, he wished to skip the injection and get the surgery done. The 8/28/14 utilization review denied the right shoulder surgery and associated requests as there was evidence of only minimal conservative treatment and no documentation of injection therapy prior to surgical consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic surgery with the Mumford procedure: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter and the Shoulder Chapter

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, Partial claviclectomy (Mumford procedure)

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. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty 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, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria for Mumford procedure 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. In this case, the guideline criteria have not been met. There is no current documentation of painful active arc of motion or abduction weakness. There is no documentation of a corticosteroid injection consistent with guideline recommendations. Evidence of 3-6 months month(s) of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Partial acromioplasty with resection of the CA ligament: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter and the Shoulder Chapter

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. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty 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, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. In this case, the guideline criteria have not been met. There is no current documentation of painful active arc of motion or abduction weakness. There is no documentation of corticosteroid injection consistent with guideline recommendations. Evidence of 3-6 months month(s) of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Debridement of the bursa: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter and the Shoulder Chapter

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)

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. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty 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, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. In this case, the guideline criteria have not been met. There is no current documentation of painful active arc of motion or abduction weakness. There is no documentation of corticosteroid injection consistent with guideline recommendations. Evidence of 3-6 months month(s) of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Possible repair of the RC, possible lysis of adhesions of the RC: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter and the Shoulder Chapter

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)

Decision rationale: The California MTUS guidelines provide general recommendations for rotator cuff repair and impingement syndrome. For rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for three months. The Official Disability Guidelines for rotator cuff repair generally require 3 to 6 months of conservative treatment. Subjective criteria include pain with active arc of motion 90 to 130 degrees and pain at night. Objective criteria include weak or absent abduction and tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of rotator cuff deficit are required. There is no current documentation of painful active arc of motion or abduction weakness. There is no documentation of corticosteroid injection consistent with guideline recommendations. Evidence of 3-6 months month(s) of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Medical clearance consultation with an internist: 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.

Chest x-ray: 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.

EKG: 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.

PET scan: 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.

Labs (CRC, PT, PTT and Chem12): 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.

UA: 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.

IFC: 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.

Micro cool: 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.

Home exercise kit: 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.

DVT compression pump stockings: 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.

Shoulder abduction brace with a CPM machine, 5 week rental: 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.