MAXIMUS Federal Services

Case Number:	CM14-0212616		
Date Assigned:	12/30/2014	Date of Injury:	05/31/2012
Decision Date:	03/25/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	12/18/2014

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. 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: California
Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 59-year-old female who reported an injury on 05/31/2012 due to a fall. On 11/07/2013, an MRI of the left shoulder without contrast revealed gross acromioclavicular joint arthritis with edema within the joint space, marginal bone hypertrophy, and capsular hypertrophy and a downsloping of the lateral acromion. There was severe tendinosis of the lateral supraspinatus tendon with the tendon thickened the 1 cm and a focal full thickness tear involving the anterolateral humeral head insertional fibers with a tendon gap of 4 - 6 mm. There was a partial thickness tear on the articular surface of the infraspinatus tendon. There was bursal surface fiber fraying over the bursal surfaces of the supraspinatus and infraspinatus tendons. There was substantial subacromial/subdeltoid bursitis noted. There was tendinosis noted of the upper most course of the long head of the biceps tendon. There was a probable superior and anterosuperior labral tear, further evaluated and characterized by postarthrogram imaging. The clinical note dated 12/01/2014 revealed the injured worker's complaints of intermittent pain and discomfort to the left knee. She also had complaints to the neck and bilateral shoulders. There was tenderness to palpation over the bilateral shoulders. Range of motion of the shoulders was normal with pain at the end ranges. The diagnoses were status post right shoulder arthroscopy, strain of the left shoulder, and probable superior and anterosuperior labral tear. The provider recommended a left shoulder arthroscopy, repair of the rotator cuff, repair of the SLAP lesion, Mumford procedure, pre-operative clearance and post-operative therapy along with post-op DME. The documentation further indicated the injured worker had a left knee arthroscopy including a partial medial meniscectomy, patelloplasty and removal of loose body on

09/11/2014. The injured worker was utilizing a knee brace and crutches to assist with walking. The physician documented that the office was still awaiting authorization for a Post-Op Q-Tech cold therapy system w/wrap x 21 day rental, a Knee CPM w/ pad x 30 days rental, a Pro-ROM post-op brace and a Pro-stim 5.0 Plus 1 month supplies x 30 days trial. The knee CPM was noted to be non-certified. A Request for Authorization form was dated 12/02/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy, repair of the rotator cuff, repair of SLAP lesion, 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)

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, SLAP lesion, Mumford procedure.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate that a referral for surgical consultation may be indicated for patients who have red-flag conditions, activity limitation for more than four months, plus existence of a surgical lesion, the failure to increase ROM and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion and clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. The further 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. Rotator cuff tears are frequently partial-thickness or smaller full thickness tears. They do not address the Mumford Procedure or SLAP lesion repair. As such, secondary guidelines were sought. The Official Disability Guidelines state that a SLAP lesion that is Type II or Type IV should be treated with surgery after a failure of 3 months of conservative care and that the definitive diagnosis is usually made intraoperatively. The Official Disability Guidelines indicate, regarding the Mumford procedure that there should be a diagnosis of post-traumatic arthritis of AC joint, a failure of conservative care for at least 6 weeks, findings of pain at AC joint; aggravation of pain with shoulder motion or carrying weight or previous Grade I or II AC separation and objective clinical findings of tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan) and/or pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. There should be imaging findings including conventional films showing either post-traumatic changes of AC joint or severe DJD of AC joint or a complete or incomplete separation of AC joint and if there is separation, there should be documentation of a bone scan that is positive for AC joint separation. The clinical documentation indicated the injured worker had a full thickness tear involving the far anterolateral humeral head insertion fibers, a partial thickness tear in the infraspinatus tendon, bursal surface fiber fraying, downsloping of the lateral acromion and gross acromioclavicular joint arthritis. Conservative care would not be necessary due to the findings of a complete tear on MRI. The requested surgical intervention would be appropriate, as per the MRI findings,

however, there was a lack of physician documentation including the objective findings of the left shoulder to support the requested surgical intervention. Therefore, given the lack of objective findings, the request for a Left shoulder arthroscopy, repair of the rotator cuff, repair of SLAP lesion, Mumford procedure is not medically necessary.

Associated surgical service: 12 post-operative physical therapy, 3 times a week for 4 weeks: Upheld

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

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.

Associated surgical service: Q-Tech cold therapy system with wrap for 21 days rental: Upheld

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) Knee & Leg Chapter, Should Chapter, Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy post-operative for the knee and the shoulder for up to 7 days. The injured worker was awaiting authorization of a unit for the knee. There was a request for DME and it was unclear what DME was being requested by the provider for the injured worker. The surgical intervention was found to be not medically necessary and there was a lack of clarification. Given the above and the lack of clarification, the Associated surgical service: Q-Tech cold therapy system with wrap for 21 days rental is not medically necessary.

Associated surgical service: knee CPM with pad for 30 days rental prior to surgery: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Continuous passive motion (CPM)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Continuous Passive Motion.

Decision rationale: The Official Disability Guidelines indicate that a continuous passive motion device is recommended after a total knee arthroplasty or an anterior cruciate ligament

reconstruction. The documentation indicated the injured worker underwent a meniscectomy, which would not support the use of this device. Given the above, the request for the Associated surgical service: knee CPM with pad for 30 days rental prior to surgery is not medically necessary.

Associated surgical service: Pro-Stim 5.0 plus one month supplies x 30 days trial: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation BlueCross BlueShield, 2005

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

Decision rationale: The California Medical Treatment Utilization Schedule recommends a TENS unit for immediate post-operative use for up to 30 days and it was indicated the injured worker was awaiting authorization of a unit for the knee. There was a request for DME and it was unclear what DME was being requested by the provider for the injured worker. The surgical intervention was found to be not medically necessary and there was a lack of clarification. Given the above and the lack of clarification, the request for Associated surgical service: Pro-Stim 5.0 plus one month supplies x 30 days trial is not-medically necessary.

Associated surgical service: Pre-op clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation htto://www.guideline.gov/content.aspz?id=48408

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.