

Case Number:	CM14-0218900		
Date Assigned:	01/08/2015	Date of Injury:	07/02/2004
Decision Date:	03/13/2015	UR Denial Date:	12/20/2014
Priority:	Standard	Application Received:	12/30/2014

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: Minnesota, Florida

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 a 64 year old male who sustained a work related injury on July 2, 2004, getting out of a truck, with a right knee contusion. The injured worker was noted to have undergone lower back fusion at L4-L5 on March 12, 2008, right total knee arthroplasty in October 2008, left shoulder arthroscopic debridement in October 2009, right carpal tunnel release in 2010, and subacromial arthroscopic decompression on March 24, 2011. The injured worker's conservative treatments were noted to have included a left shoulder corticosteroid injection and oral medications. The Primary Treating Physician's visit dated November 25, 2014, noted the injured worker with complaints of progressively increasing left shoulder pain. The Physician noted the MRI scan from November 3, 2014 was consistent with a full thickness rotator cuff tear. Physical examination was noted to show marked limitation of range of motion with pain about the left shoulder and positive impingement. The diagnosis was listed as left shoulder rotator cuff tear, status post prior decompressive acromioplasty. The Physician requested authorization for left shoulder rotator cuff repair and acromioplasty, preoperative labs, preoperative EKG, preoperative history and physical, twelve physical therapy visits, Norco 10/325 mg #60, Tramadol HCL ER 50mg #60, Anaprox 550mg #60, Keflex 500mg #28, anesthesia times one, and corticosteroid injection into the subacromial space of the left shoulder with 3cc DepoMedrol and Marcaine. On December 20, 2014, Utilization Review evaluated the request for left shoulder rotator cuff repair and acromioplasty, preoperative labs, preoperative EKG, preoperative history and physical, twelve physical therapy visits, Norco 10/325 mg #60, Tramadol HCL ER 50mg #60, Anaprox 550mg #60, Keflex 500mg #28, anesthesia times one,

and corticosteroid injection into the subacromial space of the left shoulder with 3cc DepoMedrol and Marcaine, citing the MTUS Chronic Pain Medical Treatment Guidelines, the MTUS American College of Occupational and Environmental Medicine, Chapter 9, Shoulder Complaints, the Postsurgical Medical Treatment Guidelines, the Official Disability Guidelines, Indications for Surgery, and Shoulder (Acute & Chronic), and Non-MTUS, ACOEM/ODG Guidelines. The UR Physician noted that the left shoulder surgery was not warranted as the injured worker was not documented to be unable to elevate the arm, nor were any muscle deficits noted, no painful arc or nighttime pain were present, and no recent physical therapy attempted. The UR Physician noted that the request for left shoulder rotator cuff repair and acromioplasty was non-certified. The UR Physician noted that as the surgery was non-certified, the requests for preoperative labs, preoperative EKG, preoperative history and physical, twelve physical therapy visits, anesthesia, and the Keflex 550mg #28 were unnecessary and were also non-certified. The request for Norco 10/325mg #60 was modified to approval for Norco 10/325mg # 33 with the remaining 27 non-certified. The requests for Tramadol HCL 50mg #60 and Anaprox 550mg #60 were certified. The UR Physician noted the injured worker had received at least five steroid injections to the left shoulder since September 2013, without substantial improvement of symptoms after the most recent injection, therefore, the request a corticosteroid injection into the subacromial space of the left shoulder with 3cc DepoMedrol and Marcaine was non-certified. The decisions were subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder rotator cuff repair and acromioplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder, rotator cuff repair

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

Decision rationale: The injured worker is a 64-year-old male with a date of injury of 7/2/2004. He had undergone arthroscopic subacromial decompression of the left shoulder in 2009 and again in 2011 per QME dated 11/11/2011. Documentation indicates increasing left shoulder pain with evidence of impingement. A small 2mm full-thickness rotator cuff tear was diagnosed on the MR Arthrogram of 11/03/2014. Partial thickness tears and degenerative changes were also present. California MTUS guidelines indicate surgical considerations for activity limitation of more than 4 months plus existence of a surgical lesion, failure to increase range of motion 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. Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. For partial thickness and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. Conservative treatment has results similar to surgical treatment but without

surgical risks. An 82-86% success rate is reported. Surgery for impingement syndrome is arthroscopic decompression. This 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 3-6 months before considering surgery. 2-3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears are recommended. The available documentation does not indicate a recent comprehensive nonoperative treatment program with trial/failure. Documentation indicates that a shoulder decompression was performed in 2009 and again in 2011. The current full thickness rotator cuff tear is 2 mm per Radiology report and there is no clear indication for a rotator cuff repair. As such, the request for left shoulder rotator cuff repair and acromioplasty is not supported by guidelines and the medical necessity is not established.

preoperative labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Health care protocol. Bloominton (MN): Institute for clinical systems improvement

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

Decision rationale: The requested surgery is not medically necessary. Therefore the requests for ancillary services are also not medically necessary.

preoperative EKG, preoperative history and physical: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Health care protocol. Bloominton (MN): Institute for clinical systems improvement

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

Decision rationale: The requested surgery is not medically necessary. Therefore the requests for ancillary services are also not medically necessary.

Physical therapy visits x 12 visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

Decision rationale: The requested surgery is not medically necessary. Therefore the request for post-operative physical therapy is also not medically necessary.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209, 210, 211, 213.

Decision rationale: The requested surgery is not medically necessary. therefore the request for post-operative Norco 10/325 mg # 60 is also not medically necessary.

ketaflex 500mg #28: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Health care protocol. Bloominton (MN): Institute for clinical systems improvement

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209, 210, 211, 213.

Decision rationale: The requested surgery is not medically necessary. Therefore the request for post-operative Keflex 500 mg. # 28 as a prophylactic antibiotic is also not medically necessary.

anesthesia x1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209, 210, 211, 213.

Decision rationale: The requested surgery is not medically necessary. Therefore the request for anesthesia is not applicable.

corticosteroid injection into the subacromial space of the left shoulder with 3cc depomedrol and marcaine: 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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 213.

Decision rationale: The California MTUS guidelines on page 213, table 9 6 indicate 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. This is appropriate and supported by guidelines. The utilization review denial of the corticosteroid injection request was based upon the frequency of injections at that time. However, a repeat injection would be appropriate at this time and the medical necessity is established.