

Case Number:	CM15-0011391		
Date Assigned:	01/29/2015	Date of Injury:	09/29/2001
Decision Date:	03/25/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/21/2015

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: Illinois, California, Texas
 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 (IW) is a 52year-old male, who sustained an industrial injury on 9/29/01. He was diagnosed with right shoulder rotator cuff impingement and biceps rupture. The 9/9/14 right shoulder MRI documented a rupture of the biceps tendon, tear of the labrum in the area of the biceps anchor, supraspinatus and infraspinatus tendinosis with partial tearing, and acromioclavicular (AC) joint osteoarthritis. The 10/3/14 treating physician report cited right arm pain with lifting or rotation that precluded full duty work. The treatment plan included continued home exercise program and surgical consult. The patient was off work as no modified duty was available. The 11/24/14 orthopedic report indicated that the IW sustained a right proximal biceps rupture on 9/29/01 and had returned to work. He developed continuous trauma, repetitive stress/strain injuries to the right shoulder from 9/9/13 through 9/9/14. He reported on-going right shoulder pain 8/10. Physical exam documented right shoulder range of motion as flexion 160, abduction 160, extension 40, adduction 40, external rotation 90, and internal rotation 60 degrees. There was subacromial crepitus, severe supraspinatus tenderness, and moderate greater tuberosity and biceps tenderness. There was global 4/5 weakness and painful shoulder movement. Impingement I, II, and III and AC joint compression tests were positive. Right shoulder arthroscopic evaluation with subacromial decompression, distal clavicle resection, and lateral debridement was recommended. On 12/31/14, utilization review non-certified a right shoulder arthroscopy, pre-operative surgical clearance including a 2 night home sleep study, rehabilitative therapy, a home continuous passive motion machine and a cold therapy unit for purchase, with MTUS, ACOEM Guidelines, (or ODG) cited. The rationale for non-certification

cited absence of documented functional limitations, night pain, painful arc of motion, or restricted overhead activity. There was no documentation of physical therapy, activity modification, anti-inflammatory, or subacromial corticosteroid injection. On 1/14/15, the injured worker submitted an application for IMR for review of the above requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder Arthroscopic subacromial decompression, distal clavicle resection, labral debridement and possible retrocoracoid decompression: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation 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. Guidelines state the ruptures of the biceps tendon can almost always be managed conservatively, and surgery is not necessary for function. 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 have not been met. This patient presents with a flare of his chronic shoulder condition. He was diagnosed with a biceps tendon rupture in 2001 and reported increased shoulder symptoms due to repetitive trauma from 2013-2014. Current exam findings documented mild loss of range of motion with crepitus and pain, global weakness, significant supraspinatus tenderness, and positive impingement testing. There is imaging evidence of rotator cuff partial tearing and AC joint osteoarthritis. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including injection, and failure has not been submitted. Given the absence of guideline-recommended conservative treatment for this apparent flare of a chronic injury, this request is not medically necessary.

Pre operative 2 night home sleep study polysomnogram: 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 Pain (Chronic), Polysomnography

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Pre-operative medical clearance: 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 Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Associated surgical service: rehabilitative therapy 3 times weekly for 4 weeks: Upheld

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

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

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Associated surgical service: home continuous passive motion machine, quantity: 45 days: 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 Shoulder: Continuous passive motion (CPM)

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Surgi - Stim unit, quantity: 90 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Purchase of Coolcare cold therapy unit, quantity: 1: 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 Shoulder: Continuous flow cryotherapy

Decision rationale: As the surgical request is not supported, this request is not medically necessary.