

Case Number:	CM15-0115773		
Date Assigned:	06/24/2015	Date of Injury:	02/06/2014
Decision Date:	07/22/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/16/2015

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:

This injured worker is a 27-year-old female who sustained an industrial injury on 2/6/14. Injury occurred while she was working as a baker moving trays of food in each arm, and hit the corner of a tray, causing it to topple and twist her left upper extremity. This motion caused her left shoulder to dislocate, popping out and back in. She reported four additional dislocations, three required manually relocation. The 2/2/15 second opinion orthopedic report cited left shoulder pain with history of multiple dislocations and long thoracic nerve injury with winging of the scapula. Functional limitations were noted in sleeping, driving, grasping, lifting, writing and typing. Left shoulder exam documented the scapula was protracted with obvious 2 to 3+ winging of the scapula, and diffuse tenderness to palpation. Active shoulder range of motion was abduction 70, forward elevation 170, external rotation (arm at side) 70, external rotation (90 degrees abduction) 90, extension 50, adduction 50, and internal rotation to T7. Apprehension and relocation tests were positive. There was 1+ anterior and inferior translation with negative posterior translation. X-rays were taken and within normal limits. The diagnosis was left shoulder sprain/subluxation complicated by recurrent instability, and winging with the left scapula with reported long thoracic nerve injury. The treatment plan recommended left shoulder MR arthrogram to help delineate pathology in this complicated problem. The injured worker would likely required left shoulder arthroscopy with capsulorrhaphy. The 5/6/15 left shoulder MR arthrogram impression documented no acute or chronic Hill-Sachs or Bankart deformity. There was no visualized labral tear. The superior glenohumeral ligament was prominent but intact, likely a normal variant. The middle and inferior glenohumeral ligaments were normal. The 5/27/15 treating physician report cited constant grade 6/10 left shoulder pain that radiated to the elbow with numbness in the left 3rd-5th digits. Her scapula would pop out when she tried to reach behind her low back. When she slept on the shoulder, she woke up with a completely numb arm that lasted for 15 minutes. The physical therapist would not continue as her scapula

continued to pop out. Left shoulder exam documented no swelling, mild bicipital groove tenderness, and marked tenderness of the parascapular tissues, especially medially. There was prominent winging of the left scapula, the vertebral border lifted well off the thorax. There was full range of motion, but pain and asynchronous glenohumeral scapulothoracic motion was noted with abduction, internal rotation, and extension. Strength, sensation and reflexes were intact. Speed's test was positive. Drop arm, cross arm, Yergason's, impingement, and O'Brien's tests were negative. The MR arthrogram was completely normal. The diagnosis was left biceps tenosynovitis, left shoulder joint derangement, and recurrent left shoulder dislocation. The injured worker had failed physical therapy and had on-going severe complaints requiring opioid medications. Physical exam over the past year had consistently demonstrated scapulothoracic dysfunction. The second opinion had focused on the glenohumeral joint, which had been reported completely normal and an MR arthrogram was performed which was normal. On exam, the injured worker had abnormal lift off of the scapula with regional hypersensitivity far greater than anticipated. The treatment options were to live with it or undertake surgical stabilization. Authorization was requested for left shoulder scapuloplexy and post-operative physical therapy 2 times per week for 4 weeks. The 6/9/15 utilization review non-certified the request for left shoulder scapuloplexy and associated post-operative physical therapy as there was no documentation of exercise, normal strength, no MRI evidence of capsular laxity, and no EMG findings for serratus anterior, trapezius, or rhomboid muscle paralysis to support the medical necessity of surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder scapuloplexy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goel DP, Romanowski JR, Shi LL, Warner JJ. Scapulothoracic fusion: outcomes and complications. J Shoulder Elbow Surg. 2014 Apr; 23(4): 542-7. doi: 10. 1016/j. jse. 2013. 08. 009. Epub 2013 Nov 23; Meininger AK, Figuerres BF, Goldberg BA. Scapular winging: an update. J Am Acad Orthop Surg. 2011 Aug;19(8):453- 62.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The MTUS and Official Disability Guidelines do not specifically address the treatment of scapular winging. Peer reviewed literature reported that scapulothoracic fusion was an option to alleviate pain and restore function in painful scapular winging. Literature indicates that most cases resolve non-surgically, but surgical treatment of scapular winging was successful. Guideline criteria have been met. This injured worker presents with persistent painful scapular winging and clinical exam findings of scapulothoracic dysfunction. She had failed over a year of conservative treatment, including physical therapy. There were significant functional deficits that precluded return to work, and recurrent dislocations. Imaging did not evidence any other shoulder pathology. Given the functional deficits and clinical exam findings, this request is consistent with literature. Therefore, this request is medically necessary.

Post operative Physical therapy 2 times a week for 4 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for shoulder dislocation suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.