

Case Number:	CM15-0121403		
Date Assigned:	07/02/2015	Date of Injury:	05/03/2013
Decision Date:	07/30/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	06/23/2015

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 35-year-old male who sustained an industrial injury on 5/03/13, relative to a cumulative trauma. The 7/11/13 left shoulder MRI impression documented tendinosis of the rotator cuff with a partial tear, fluid in the subdeltoid space, and mild impingement. The 7/11/14 right knee MRI documented an IIIA abnormality of the posterior horn of the medial meniscus representing a tear, mild tendinitis of the quadriceps ligament, and partial tear of the posterior fibers of the posterior horn of the posterior cruciate ligament. Conservative treatment included oral medications, topical medications, acupuncture, physical therapy, chiropractic treatment, and activity modification. The 5/18/15 orthopaedic consultation report cited constant moderate right knee pain with swelling and numbness. Pain increased to a severe level with standing, pivoting, climbing, walking over uneven ground, squatting, kneeling, crouching, crawling and weight bearing. He experienced locking and giving way of the knee. Left shoulder/upper arm pain was reported constant and moderate increasing to a severe level with pushing, pulling, twisting, torqueing, lifting, carrying, and reaching above shoulder level. He reported difficulty sleeping due to pain and difficulty performing overhead activities. Left shoulder exam documented moderate pain and tenderness over the acromioclavicular (AC) joint, periacromial area, and bicipital groove. Range of motion was restricted to flexion 110, extension 30, abduction 100, adduction 30, internal rotation 50, and external rotation 60 degrees. Passive range of motion testing documented flexion 120 and abduction 130 degrees. Impingement, Speed's, Neer's, Drop-arm, Yergason's, and Abrasion tests were positive over the left shoulder. There was 4/5 deltoid, biceps, and triceps weakness. Right knee exam documented swelling, palpable fluid in the right

knee, positive ballottement, and moderate to severe tenderness globally. Right knee range of motion was flexion 90, extension -5, internal rotation 20, and external rotation 10 degrees. Valgus stressing and anterior drawer tests were positive. McMurray's, Apley's grind, and patellar compression tests were positive on the right. The injured worker was unable to squat-rise, duck-walk, tip-toe walk or heel walk on the right due to pain. There was 4/5 weakness over the iliopsoas, quadriceps, and tibialis anterior. The diagnosis was sprain/strain of the left shoulder with impingement syndrome, rotator cuff tear, tendonitis, AC joint arthrosis, and subacromial bursitis, and right knee sprain/strain, internal derangement, medial meniscus tear, and posterior cruciate ligament tear. The injured worker had failed exhaustive conservative treatment, including subacromial injections with only temporary clinical benefit. Authorization was requested for left shoulder arthroscopy, right knee arthroscopy, and one month rental of a post-operative TENS (transcutaneous electrical nerve stimulation) unit with electrodes, batteries, set up and delivery. The 6/17/15 utilization review non-certified the request for left shoulder arthroscopy as there was no documentation of exhaustion of conservative care and imaging was from 2013. The request for right knee arthroscopy was non-certified as there was no documentation of conservative treatment and imaging was from 2013. The request for one month rental of a TENS unit was non-certified as the associated surgeries were not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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; Surgery for rotator cuff repair.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery and rotator cuff surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome and partial thickness rotator cuff repairs 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, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement or rotator cuff deficiency. Guideline criteria have been met. This injured worker presents with persistent and function-limiting left shoulder pain. Clinical exam findings are consistent with imaging evidence of rotator cuff pathology and impingement. There was a positive diagnostic injection test documented. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Right knee arthroscopy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Meniscectomy.

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who have activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. Guidelines support arthroscopic partial meniscectomy for cases in which there is clear evidence of a meniscus tear including symptoms other than simply pain (locking, popping, giving way, and/or recurrent effusion), clear objective findings, and consistent findings on imaging. The Official Disability Guidelines criteria for meniscectomy include conservative care (exercise/physical therapy and medication or activity modification) plus at least two subjective clinical findings (joint pain, swelling, feeling or giving way, or locking, clicking or popping), plus at least two objective clinical findings (positive McMurray's, joint line tenderness, effusion, limited range of motion, crepitus, or locking, clicking, or popping), plus evidence of a meniscal tear on MRI. Guideline criteria have been met. This injured worker presents with persistent left knee pain and swelling with complaints of locking and giving way. Functional limitations are documented. Clinical exam findings are consistent with imaging evidence of medial meniscus tear and posterior cruciate ligament tear. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Associated surgical service: TENS unit, electrodes, batteries, set up and delivery - 1 month
rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS - Transcutaneous Electrical Nerve Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post-operative pain (transcutaneous electrical nerve stimulation) Page(s): 116-117.

Decision rationale: The California MTUS guidelines recommend TENS use as a treatment option for acute post-operative pain in the first 30 days after surgery. TENS appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. Guidelines state that the proposed necessity of the unit should be documented. Guidelines have not been met. Shoulder and knee arthroscopic surgeries have been requested. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the injured worker was intolerant or unresponsive to pain medications during the pre-operative period. Therefore, this request is not medically necessary.

