

Case Number:	CM15-0126743		
Date Assigned:	07/13/2015	Date of Injury:	04/15/2013
Decision Date:	09/22/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	06/30/2015

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 60-year-old female who sustained an industrial injury on 4/15/13. Injury occurred when she was carrying a box of pears, and tripped over a box of apples. She landed on the floor with brief loss of consciousness. She underwent left hip arthroscopic femoral neck resection with debridement of the labrum on 11/26/14. Conservative treatment for the shoulder included corticosteroid injection, modified duty, and medications. The 8/1/13 right shoulder MRI impression documented a degenerative type II SLAP tear at the base of the superior labrum propagating from at least 11:00 to 1:00 with findings consistent with possible further anterior extension of the SLAP tear or a coexistent sub-labral foramen. There was mild 5mm sagittal bursal sided fraying of the distal supraspinatus tendon. The 2/20/15 treating physician report cited right shoulder pain and clicking. Right shoulder exam documented decreased range of motion, painful arc of motion, and positive Neer, Hawkins, and O'Brien's tests. The diagnosis included right shoulder impingement, rotator cuff tear, and labral tear. A right shoulder corticosteroid injection was performed. The 5/22/15 treating physician report indicated that the right shoulder felt better following injection but the effects had tapered off and pain had increased. She reported 12 migraine headaches over the past month averaging 1-3 days. The diagnosis included right shoulder impingement. Authorization was right shoulder arthroscopy, subacromial decompression, rotator cuff repair, and labral repair versus debridement, medical clearance, post-operative Norco 10/325 quantity unspecified, post-operative shoulder sling purchase, and post-operative physical therapy right shoulder 12 sessions. The 6/24/15 utilization review non-certified the right shoulder arthroscopy, subacromial decompression, rotator cuff

repair, and labral repair versus debridement and associated surgical requests as there were no current exam and imaging findings to support the medical necessity of surgery at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder arthroscopy, subacromial decompression, rotator cuff repair, and labral repair versus debridement: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery, Acromioplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome; Surgery for rotator cuff repair, Surgery for SLAP 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 (ODG) 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. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. SLAP surgery is recommended for patients under age 50, otherwise biceps tenodesis is recommended. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have been met. This injured worker presents with persistent and function-limiting right shoulder pain. Clinical exam findings have been consistent with imaging evidence of labral and rotator cuff pathology and plausible impingement. There is evidence of a positive diagnostic injection test. Evidence of at least 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Therefore, this request is medically necessary.

Associated Surgical Service: Medical Clearance: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery, Acromioplasty.

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: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient age, long-term use of non-steroidal anti-inflammatory drugs, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Associated Surgical Service: Post-Operative Norco 10/325mg quantity unspecified:
Overturned

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): 212, Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): s 76-80 and 91.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient age, long-term use of non-steroidal anti-inflammatory drugs, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Associated Surgical Service: Post-Operative Shoulder Sling Purchase: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 205 and 213.

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.

Associated Surgical Service: Post-Operative Physical Therapy, right shoulder, 12 sessions:
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 impingement syndrome and rotator cuff repair 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. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that 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.