

Case Number:	CM15-0128920		
Date Assigned:	07/15/2015	Date of Injury:	05/21/2014
Decision Date:	08/19/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/02/2015

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 37-year-old male who sustained an industrial injury on 5/21/14. Injury was reported relative to cumulative trauma in his occupation as a police officer. Past medical history was positive for hypertension, hypertensive heart disease, sinus tachycardia, and anemia. Past surgical history was positive for four right wrist surgeries, including a right wrist fusion on 1/27/14, and left knee meniscectomy and chondroplasty on 5/15/15. The 2/27/15 shoulder MRI impression documented evidence of subacromial bursitis with supraspinatus tendinosis or reactive peritendinitis just proximal to the critical zone at the supraspinatus tendon. There was no rotator cuff tear and the biceps labral complex was intact. Imaging documented a type II acromial slant, consistent with moderate anatomic risk for impingement. The 6/16/15 treating physician report cited persistent left shoulder pain and right wrist effusion. He had exhausted conservative treatment for this left shoulder including physical therapy, rest, ice, anti-inflammatories, analgesics, and corticosteroid injection without sustained improvement. Physical exam documented forward flexion and abduction to 155 degrees with pain in range of motion, positive impingement signs, and 4/5 strength. The diagnosis included bilateral rotator cuff tendinitis. Authorization was requested for left shoulder diagnostic/operative arthroscopic debridement with acromioplasty, resection of coracoacromial ligament and bursa, possible distal clavicle resection with examination and manipulation under anesthesia and associated surgical requests. Authorization was also requested for a home health nurse for 48 hours for post-operative care as he used his left hand for the majority of his hygiene and activities of daily living as he had right wrist effusion. The 6/29/15 utilization review modified the request for the

left shoulder diagnostic/operative arthroscopic debridement with acromioplasty, resection of coracoacromial ligament and bursa, possible distal clavicle resection with examination and manipulation under anesthesia, to left shoulder diagnostic/operative arthroscopic debridement with acromioplasty, resection of coracoacromial ligament and bursa. The rationale for non-certification indicated that guideline criteria had not been met for distal clavicle excision or manipulation under anesthesia. The request for a post-op home health nurse visit for 48 hours was non-certified as guidelines had not been met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Diagnostic/Operative Arthroscopic Debridement with Acromioplasty, Resection of Caracoacromial Ligament and Bursa, Possible Distal Clavicle Resection with Examination and Manipulation under Anesthesia: Upheld

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 (Acute & Chronic), Surgery for impingement syndrome; Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome; Surgery for rotator cuff repair; Partial claviclectomy; Manipulation under anesthesia (MUA).

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 for partial claviclectomy include subjective and objective clinical findings of acromioclavicular (AC) joint pathology. Manipulation under anesthesia is under study as an option for adhesive capsulitis. In cases, that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90), manipulation under anesthesia may be considered. Guideline criteria have not been met for manipulation under anesthesia. This injured worker presents with persistent and function-limiting left shoulder pain. Clinical exam findings were consistent with imaging evidence of impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The 6/29/15 utilization review modified this request and certified left shoulder diagnostic/operative arthroscopic debridement with acromioplasty, and resection of coracoacromial ligament and bursa. There is no compelling rationale provided to support the medical necessity of manipulation under anesthesia in the absence of adhesive capsulitis. Therefore, this request is not medically necessary.

Post-operative Home Health Nurse Visit for 48 hours: 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 Home health services Page(s): 51.

Decision rationale: The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Guideline criteria have not been met. There is no evidence that the patient is or will be homebound following surgery. There is no evidence or physician recommendation evidencing the need for skilled nursing care in the home environment. There is no clear documentation as the type of home health services being recommended for this patient to establish medical necessity. Therefore, this request is not medically necessary.