

Case Number:	CM15-0174465		
Date Assigned:	10/28/2015	Date of Injury:	06/01/2015
Decision Date:	12/08/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/04/2015

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 20-year-old female who sustained an industrial injury on 6/1/15. The injured worker reported a pop followed by pain in her right shoulder due to repetitively lifting and pushing 10 pound boxes onto and off a shelf over her shoulder height. She had worked as a sandwich maker for two days at the time of the reported injury. Past surgical history was positive for left shoulder arthroscopy with Bankart repair and open reduction and internal fixation of os acromiale on 6/13/13, and right shoulder arthroscopy with repair of humeral avulsion glenohumeral ligament and open reduction and internal fixation of os acromiale with arthroscopic anterior capsulorrhaphy on 8/14/14. The 6/3/15 right shoulder x-rays showed no acute fracture or dislocation. The alignment was normal and no significant joint disease or soft tissue abnormality was identified. The 6/11/15 right shoulder MRI impression documented no evidence of rotator cuff tear and minimal supraspinatus and infraspinatus tendinopathy. The acromion process was completely obscured by a large amount of artifact. There was no discrete labral tear or paralabral cyst detected. The 6/23/15 orthopedic consult cited anterior and posterior shoulder pain and right trapezial area pain. She refused any injected studies of the shoulder and did not like to take pain medications. She had decreased range of motion with forward flexion to 90 degrees with guarding, tenderness, pain, spasms and decreased strength. There was no swelling. The treating physician opined this was a tough problem with prior right shoulder surgery and re-injury that sounded like a subluxation episode with pain. The MRI showed a lot of scatter so less useful information about the labrum. The treatment plan recommended a CT scan and second opinion. The 6/26/15 right shoulder CT scan impression documented status post open reduction internal fixation (ORIF) of fracture of the acromion and

there was no evidence of acute fracture or hardware failure. The 7/3/15 right shoulder x-ray impression documented a screw in the acromion transfixing fracture which was healing or almost healed. Acromioclavicular joint space was narrowed suggestive of degenerative change. Glenohumeral joint was unremarkable. There was no acute fracture or dislocation evident. The 7/15/15 orthopedic second opinion report indicated that the injured worker had right shoulder pain with numbness and paresthesia from the neck to the elbow. She had not been in any physical therapy. Physical exam documented right shoulder range of motion with forward flexion 70 degrees, external rotation 30, and internal rotation 40 degrees. There were positive Neer's, Hawkin's, Cross arm, Paxino's, Yergason's and restricted cross shoulder tests. He was unable to test Speed's or O'Brien's tests or painful arc. There was tenderness over the supraspinatus, biceps tendon, and acromioclavicular joint. There was 4/5 right rotator cuff strength. The exam was reported very limited by patient effort, cooperation and guarding. Family was insistent on surgical treatment and was not willing to listen to recommendations for physical therapy. She refused MR arthrogram and will not "do needles". She felt that she had damage that the MRI did not see and felt that surgery was the only option to find out what was really wrong. Her current shoulder state of dysfunction was not characteristic in any way of a purely anatomic lesion, but mostly the result of inflammation and dynamic dysfunction. The orthopedist discussed the importance of therapy to strengthening the muscles around the shoulder. A third opinion was offered. The 8/10/15 treating physician report cited complaints of grade 8/10 right shoulder pain with any movement and mild to moderate pain at rest. She was using Motrin or Tylenol as needed. She reported the right shoulder felt loose with very limited motion. She felt that something was torn again. She had to brace it and was guarding. She was convinced that some was wrong with the right shoulder and surgery was the only way to fix the problem. Physical exam documented decreased range of motion with guarding. Flexion was 80, extension 20, and abduction 70 degrees. There was no bony tenderness, deformity, swelling or spasms. There was a positive sulcus sign and pain with decreased strength. The diagnosis was right rotator cuff syndrome and instability of the right shoulder joint. Surgery was requested per the orthopedic surgeon recommendations. She was to perform light exercises and stretching and continue modified work. Authorization was requested for right shoulder arthroscopy with possible decompression/debridement, rotator cuff repair/reconstruction, biceps tenotomy/tenodesis, and capsulorrhaphy, labral repair and 12 sessions of post-operative physical therapy. The 8/18/15 utilization review non-certified the requested right shoulder surgery and associated post-op physical therapy but there was no diagnosis that correlated well with the symptoms and the injured worker appeared to have "refused" more conservative treatment and some forms of diagnosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with possible decompression/debridement, rotator cuff repair/reconstruction, biceps tenotomy/tenodesis, and capsulorrhaphy, labral repair:

Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome; Surgery for rotator cuff repair; Surgery for SLAP lesions.

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. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. 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. Guidelines recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have not been met. This injured worker presents with complaints of right shoulder pain, weakness, and limited motion. Clinical exam was reported as limited by this injured worker's effort and guarding. There was no significant pathology noted on the MRI or CT scan. There is no documentation that this injured worker has completed a 3 to 6 month trial of recent, reasonable and/or comprehensive non-operative treatment protocol trial and failed. Additionally imaging was recommended but refused by the injured worker. There is not clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. Therefore, this request is not medically necessary.

Post-op physical therapy x 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.