

Case Number:	CM15-0033819		
Date Assigned:	02/27/2015	Date of Injury:	02/23/2010
Decision Date:	04/13/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	02/23/2015

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: Minnesota, Florida
 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:

The injured worker is a 48-year-old male who sustained a work related injury on February 23, 2010, when a forklift was carrying three steel racks and two of them fell upon the injured worker injuring his neck, back, right shoulder and scapula. He was diagnosed with internal derangement and labral tear of the right shoulder. Treatment included steroid injections, medications and activity modification. Currently, the injured worker complained of increased pain and limited range of motion of the right shoulder. On February 3, 2015, a request for a right shoulder diagnostic arthroscopic and surgery, subacromial decompression and tissue repair, labrum or rotator cuff was modified to a subacromial decompression and repair of the labrum by Utilization Review; a request for a cold unit rental for 7 days was certified by Utilization Review; a request for pre-operative medical clearance; shoulder sling with abduction pillow and pain pump, was non-certified by Utilization Review, noting the California Medical Treatment Utilization Schedule Guidelines, Official Disability Guidelines and American College of Occupational and Environmental Medicine Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Diagnostic Arthroscopy & Surgery, subacromial decompression and tissue repair labrum or rotator cuff as indicated and able: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th edition (web), Shoulder (acute & Chronic), Indications for surgery-Acromioplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Diagnostic arthroscopy.

Decision rationale: The documentation provided includes an MRI scan with contrast dated December 15, 2014, which revealed mild supraspinatus tendinopathy without focal tear, normal infraspinatus, teres minor and subscapularis tendons without tear or tendinosis. There was a type II SLAP lesion noted. There was degenerative arthrosis of the acromioclavicular joint and a type II acromion. In the opinion of the radiologist, there was evidence of impingement. California MTUS guidelines indicate surgery for impingement syndrome is usually arthroscopic decompression. A rotator cuff repair is indicated for significant tears that impair activities by causing weakness of the arm elevation or rotation, particularly acutely in younger workers. For partial-thickness or smaller full-thickness tears conservative therapy is recommended for 3-6 months and surgery is reserved for cases failing conservative therapy. A rotator cuff repair is indicated after firm diagnosis of a full-thickness rotator cuff tear is made and rehabilitation efforts have failed. The documentation provided indicates the presence of impingement syndrome but there is no full-thickness rotator cuff tear. As such, a rotator cuff repair is not indicated. The diagnosis is not equivocal. The MR arthrogram is fairly clear with regard to the diagnosis. As such, a diagnostic arthroscopy is not necessary. In light of the foregoing, the utilization review modification of the surgery to arthroscopic subacromial decompression and SLAP repair was appropriate. The medical necessity of the rotator cuff repair and diagnostic arthroscopy is not established.

Medical Clearance Consisting: Labs, EKG, Chest X-rays, Right shoulder j x-rays: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th edition (web), 2014, Shoulder (acute & chronic) Radiography Indications for imaging-Pain, Low Back- Lumbar & Thoracic (acute & chronic, Preoperative lab testing.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208, 209. Decision based on Non-MTUS Citation ODG: Section: Low Back, Pre-operative testing, Laboratory; Preoperative testing, general; Pre-operative testing, electrocardiography ODG, Section: Shoulder, Topic: Radiography.

Decision rationale: California MTUS guidelines indicate anatomic definition by means of imaging is commonly required to guide surgery or other procedures. When surgery is being considered for a specific anatomic defect, for example a full-thickness rotator cuff tear, magnetic resonance imaging and arthrography have similar diagnostic and therapeutic impact and

comparable accuracy although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because it demonstrates soft tissue anatomy better. The injured worker has already had an arthrogram and also an MRI scan. The specific anatomic defect has been identified. As such, additional imaging with a routine x-ray is not medically necessary. ODG indications for imaging plain radiographs of the shoulder include 1. Acute shoulder trauma, rule out fracture or dislocation. 2. Acute shoulder trauma, questionable bursitis, blood calcium/approximately 3 months duration, first study. Shoulder arthrography is still the imaging gold standard as it applies to full-thickness rotator cuff tears with over 99% accuracy. In light of the foregoing, in the presence of shoulder arthrography and MRI, the medical necessity and appropriateness for a shoulder x-ray is not established. With regard to preoperative testing ODG guidelines do not recommend electrocardiography for low risk procedures. Arthroscopy of the shoulder is considered a low risk surgical procedure. ODG guidelines recommend preoperative laboratory testing depending upon comorbidities. The guidelines suggest identifying patients at high risk of postoperative complications by conducting a thorough history and physical examination with selective testing based on the clinician's findings. Routine preoperative laboratory testing is not recommended. Routine chest x-rays are also not recommended. The available documentation does not indicate comorbidities. As such, the request for preoperative laboratory testing, electrocardiography, and chest x-ray is not supported and the medical necessity has not been substantiated.

Shoulder Sling with Abduction Pillow, Pain Pump (purchase): 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) Treatment Index, 11th Edition (web), 2014, Shoulder (Acute & Chronic) Postoperative Abduction pillow sling.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Pain pump, Post-operative abductor pillow sling.

Decision rationale: Postoperative pain pumps are not recommended by ODG guidelines after shoulder surgery. 3 recent moderate quality randomized controlled trials did not support the use of pain pumps. As such, the request for a postoperative pain pump is not supported and the medical necessity is not established. With regard to postoperative abduction pillow sling, the ODG guidelines recommend its use as an option following open repair of large and massive rotator cuff tears. The MRI scan does not show a large and massive rotator cuff tear and as such, the medical necessity of this request has not been substantiated.