

Case Number:	CM15-0044976		
Date Assigned:	03/17/2015	Date of Injury:	08/01/1999
Decision Date:	05/14/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	03/10/2015

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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 73-year-old male who reported an injury on 08/01/1999. The mechanism of injury reportedly occurred as cumulative trauma. He is diagnosed with rotator cuff tear, osteoarthritis, and shoulder impingement. His past treatments have included physical therapy and injections. Diagnostic studies included an MRI of the left shoulder performed on 03/19/2010 which showed rotator cuff fraying, partial tearing with labral tearing, and degeneration. His surgical history was noncontributory. The injured worker presented on 02/18/2015 with complaints of continued pain in his left shoulder. The clinical note indicated that the injured worker has been having pain that has worsened over the last few years and the injured worker now has increased weakness where he cannot draw back his bow anymore. The injured worker denied any constitutional symptoms. Upon physical examination of the left shoulder, the injured worker had a positive impingement sign. There was tenderness over the AC joint. There was pain and mild weakness with rotator cuff isolation. There was a positive O'Brien's sign. The injured worker had active forward elevation to 160 degrees, external rotation to 45 degrees, and internal rotation to T12. His current medication regimen included AndroGel cream, prednisone 5 mg, NovoLog 70/30, Lantis, tamsulosin, ibuprofen, methocarbamol, and Norco. The treatment plan included restrictions from lifting with the left shoulder and a request for an MRI and pending shoulder surgery. The rationale for the request was not submitted. A Request for Authorization form signed on 01/29/2015 was included with the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI with contrast of the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 217. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Imaging Magnetic resonance imaging.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for MRI without contrast of the left shoulder is not medically necessary. The injured worker has left shoulder pain. The California ACOEM Guidelines state that the primary criteria for ordering imaging studies are the emergence of a red flag; physiologic evidence of tissue insult or neurovascular dysfunction, such as weakness from the massive rotator cuff tear; the presence of edema, cyanosis, or Raynaud's phenomenon. Additionally, the guideline states the criteria includes failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure, such as a full thickness rotator cuff tear not responding to conservative treatment. The documentation submitted for review failed to provide evidence that the injured worker has a full thickness rotator cuff tear. Additionally, the documentation submitted for review failed to provide evidence of failure to progress in a strengthening program intended to avoid surgery. In the absence of the aforementioned documentation, the request as submitted was not medically necessary.

Left Shoulder Arthroscopy rotator cuff repair, biceps tenodesis, subacromial decompression, distal clavical resection and repairs as indicated by surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Integrated Treatment/Disability Duration Guidelines, Shoulder (acute & Chronic), Indications for Surgery - Acromioplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: The request for left shoulder arthroscopy rotator cuff repair, biceps tenodesis, subacromial decompression, distal clavicle resection, and repairs as indicated by surgeon is not medically necessary. The injured worker has left shoulder pain. The California ACOEM Guidelines state that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger patients. Additionally, the guideline states that for partial thickness rotator cuff tears and small thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The documentation submitted for review failed to provide evidence of the injured worker failing conservative therapy for 3 months. Additionally, the

guidelines state that in regard to biceps tenodesis, it almost always be managed conservatively because there are no accompanying functional disabilities and surgery may be desired for cosmetic reasons, especially by young body builders, but is not necessary for function. Furthermore, in regard to subacromial decompression, the guidelines state that conservative care, including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. However, the documentation submitted for review indicated that the injured worker has received an injection, albeit the documentation failed to name the injection, and the documentation only listed 1 injection administered to the left shoulder. In regard to the request for a distal clavicle resection, the guidelines state that resection of outer clavicle for chronic disabling AC joint pain is recommended after conservative care of acute separation. The California ACOEM Guidelines state that if pain persists after recovery and return to activities, resection of the outer clavicle may be indicated after 6 months to 1 year, although local cortisone injections can be tried. The documentation submitted for review indicated that the injured worker had an injection to the shoulder, although the documentation submitted for review did not indicate what type of injection was received in the left shoulder. As such, the request for left shoulder arthroscopy rotator cuff repair, biceps tenodesis, subacromial decompression, distal clavicle resection, and repairs as indicated by surgeon is not medically necessary.

Ultrasling: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Postoperative abduction pillow sling.

Decision rationale: The request for UltraSling is not medically necessary. The injured worker has left shoulder pain. The Official Disability Guidelines recommend post-operative abduction pillow slings as an option following open repair of large and massive rotator cuff tears. The documentation submitted for review failed to provide evidence of the injured worker having a large and massive rotator cuff tear. Additionally, the guideline states that abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. Furthermore, the documentation submitted for review failed to provide evidence to meet medical necessity of an arthroscopic repair. As such, the request for UltraSling is not medically necessary.