

Case Number:	CM15-0062125		
Date Assigned:	04/08/2015	Date of Injury:	02/01/2010
Decision Date:	06/02/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/01/2015

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 63 year old male, who sustained an industrial injury on 2/1/10. The mechanism of injury was not provided. The diagnoses have included bilateral shoulder impingement syndrome, right shoulder worse than the left, right rotator cuff tear with osteoarthritis of the acromioclavicular joint and bicipital tenosynovitis. Surgery has included left shoulder arthroscopy. Treatment to date has included medications, injections, physical therapy and diagnostics. The Magnetic Resonance Imaging (MRI) of the right shoulder was done on 8/23/10. Currently, as per the physician progress note dated 1/19/15, the injured worker had undergone left shoulder arthroscopy surgery and repair of cuff on 11/16/15 and was attending physical therapy. He continues to complain of pain in the neck, back and right shoulder which he states hurts all the time and that he has difficulty with heavy lifting, pushing or pulling activities. He also states that he has difficulty with sleeping. The objective findings for the right shoulder exam revealed tenderness to palpation. The physician noted that at the time the injured worker was receiving physical therapy for the left shoulder and was advised to continue with it. He was also advised that right shoulder surgery was needed and would be scheduled. The physician requested treatments included Arthroscopic Examination, Subacromial Decompression, Repair of Rotator Cuff Right Shoulder, Medical Clearance, Cold Therapy Unit, DME (durable medical equipment), Ultrasling, Post-operative Physical Therapy 12 Visits, Assistant Surgeon, and Trigger Point Injection of the Lumbar Spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Examination, Subacromial Decompression, Repair Of Rotator Cuff Right Shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 209, 211, and 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder chapter - Indications for Surgery.

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

Decision rationale: The ACOEM guidelines indicate a surgical consultation may be appropriate for injured workers who have a failure to increase range of motion and strength of musculature in the shoulder after exercise programs and who have clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. For injured workers with a partial thickness or small full thickness tear, impingement surgery is reserved for cases failing conservative care therapy for 3 months and who have imaging evidence of rotator cuff deficit. For surgery for impingement syndrome, there should be documentation of conservative care including cortisone injections for 3 to 6 months before considering surgery. The clinical documentation submitted for review indicated the injured worker had impingement syndrome and a positive Neer's sign and thumbs down test. The MRI of 07/12/2014 revealed the injured worker had a full thickness 18 mm supraspinatus tear in the right shoulder. The injured worker had a high grade partial thickness tear in the subscapularis tendon in the right shoulder and a partial tear in the biceps tendon at the rotator interval. As the injured worker had a full thickness tear, a failure of an exercise program would not be necessary. An exercise program would not repair the full thickness tear. Additionally, the injured worker was noted to have a type 2 acromion. Given the above, the request for arthroscopic examination, subacromial decompression, repair of rotator cuff right shoulder is medically necessary.

Medical Clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI) June 2010, page 40.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.choosingwisely.org/?s=preoperative+surgical+clearance&submit=>.

Decision rationale: Per the Society of General Internal Medicine Online, "Preoperative assessment is expected before all surgical procedures." As the surgical intervention was found to be medically necessary, a medical clearance would be appropriate.

Cold Therapy Unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Continuous flow cryotherapy.

Decision rationale: The Official Disability Guidelines indicate a cold therapy unit is appropriate for postoperative care for up to 7 days. The request as submitted, however, failed to indicate the duration of use and whether the unit was for rental or purchase. Given the above, the request for cold therapy unit is not medically necessary.

DME (durable medical equipment): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable medical equipment (DME).

Decision rationale: The Official Disability Guidelines indicate that durable medical equipment is appropriate if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. The specific durable medical equipment that was being requested was not provided. As such, this request would not be supported. Given the above, the request for durable medical equipment is not medically necessary.

Ultrasling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Immobilization, Postoperative abduction pillow sling.

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

Decision rationale: The Official Disability Guidelines indicate a postoperative abduction pillow sling is recommended following the open repair of a large or massive rotator cuff tear. The clinical documentation submitted for review indicated the injured worker had a full thickness 18 mm supraspinatus tear in the right shoulder. However, there was a lack of documentation indicating the injured worker would undergo an open repair of the tear. Given the above, the request for ultrasling is not medically necessary.

Post-operative Physical Therapy 12 Visits: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California MTUS Postsurgical Treatment Guidelines indicate that for the treatment of rotator cuff syndrome and impingement syndrome, 24 visits is appropriate. The initial quantity of sessions is half the recommended number. The request as submitted failed to indicate the specific body part to be treated. This request would be supported for 12 visits, if there was documentation of the body part to be treated. Given the above, the request for postoperative physical therapy 12 visits is not medically necessary.

Assistant Surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross/Blue Shield North Carolina: Co-Surgeon, Assistant Surgeon and Assistant at Surgery Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Surgical assistant.

Decision rationale: The Official Disability Guidelines indicate that surgical assistants are appropriate for use with more complex surgeries. This would be considered a complex surgery. The surgical intervention was found to be medically necessary. As such, the request for an assistant surgeon would be appropriate. Given the above, the request for assistant surgeon is medically necessary.

Trigger Point Injection Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 121 and 122.

Decision rationale: The California Medical Treatment Utilization Schedule recommends trigger point injections for myofascial pain syndrome and they are not recommended for radicular pain. Criteria for the use of Trigger point injections include documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; Symptoms have persisted for more than three months; Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; Radiculopathy is not present (by exam, imaging, or neuro-testing). The clinical documentation submitted for review failed to provide documentation of circumscribed trigger points with evidence upon palpation of a twitch response and referred pain. There was a lack of

documentation indicating medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs, and muscle relaxants had failed to control pain. There was a lack of documentation of myotomal and dermatomal findings to indicate the injured worker did not have radiculopathy. Additionally, the request as submitted failed to indicate the quantity of trigger point injections being requested. Given the above, the request for trigger point injection lumbar spine is not medically necessary.