

Case Number:	CM15-0096807		
Date Assigned:	05/27/2015	Date of Injury:	05/23/2013
Decision Date:	08/24/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/19/2015

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

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 60 year old male, who sustained an industrial injury on 5/23/13. He reported initial complaints of neck and right shoulder pain. The injured worker was diagnosed as having chronic subacromial impingement syndrome right shoulder; degenerative joint disease severe shoulder; partial thickness undersurface supraspinatus and infraspinatus tendon tear; superior labrum degenerative type I SLAP tear; chronic bilateral medial and lateral epicondylitis elbows; ulnar neuritis and/or median neuritis; myofascial complaints of cervical spine; left shoulder pain with elements of adhesive capsulitis; depression; anxiety. Treatment to date has included status post right shoulder arthroscopic subacromial decompression, distal clavicle resection/Mumford procedure, extensive debridement of partial thickness undersurface supraspinatus/infraspinatus tendon tear, extensive debridement superior labrum degenerative type I SLAP tear (7/16/14); physical therapy; acupuncture; medications. Diagnostics included MRI left shoulder (12/16/14); MRI cervical spine (12/16/14); EMG/NCV study upper extremities (12/16/14). Currently, the PR-2 notes dated 3/30/15 indicated the injured worker was in this office for a comprehensive orthopedic evaluation. The notes document the injured worker was advised that surgery may be indicated for his left shoulder pain complaint as an MRI scan of the left shoulder date 12/16/14 revealed an anterior glenoid labral tear and SLAP tear on 7/16/14. The injured worker reports pain levels of this date as 9/10 for the left shoulder. A physical examination is documented noting right shoulder extensive arthroscopic shoulder surgery on 7/16/14. The left shoulder is noted to have restricted range of motion, severe tenderness of the supraspinatus and AC joint and moderate tenderness of the greater tuberosity. There is noted subluxation, moderate anterior translation and anterior apprehension; he was

able to reproduce symptoms and the relocation test is positive. Muscle tone and strength note shoulder movement as pain and testing is affected by pain with forward flexion, abduction, external and internal rotation is noted as 4/5. Provocative testing were all positive for AC joint compression test, impingement I, II and III and Speed and O'Brien test were with negative findings. The MRI of the left shoulder dated 12/16/14 was reviewed on this date and the impression is an anterior glenoid labrum tear/SLAP lesion and mild tendinosis of the superior fibers of the subscapularis tendon. He also has an EMG/NCV study of the bilateral upper extremities dated 1/16/14 indicate findings of early peripheral neuropathy but no evidence of carpal tunnel syndrome or cubital tunnel syndrome. EMG revealed no acute or chronic denervating changes. Note radiculopathies are "irritative" or sensory in nature and do not cause significant axonal degeneration may not be detected by either conventional EMG or NCV studies. The provider's treatment plan includes the requested: Arthroscopic left shoulder decompression, distal clavicle resection, labral debridement versus repair, and superior labrum anterior and posterior tear debridement versus repair; preoperative medical clearance; supervised post-operative rehabilitation therapy 3 times a week for 4 weeks; continuous passive motion device for initial period of 45 days; shoulder immobilizer with abduction pillow; surgi-stim unit for initial period of 90 days and Coolcare cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic left shoulder decompression, distal clavicle resection, labral debridement versus repair, and superior labrum anterior and posterior tear debridement versus repair:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder, surgery for slap lesions.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty surgery.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 3/30/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 3/30/15 does not demonstrate evidence satisfying the above criteria. Therefore the determination is not medically necessary.

Associated surgical services: Standard pre-operative medical clearance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated surgical services: Supervised post operative rehabilitative therapy 3 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated surgical services: Continuous passive motion device for initial period of 45 days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated surgical services: Shoulder immobilizer with abduction pillow: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated surgical services: Surgi-stim unit for initial period of 90 days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated surgical services: Coolcare cold therapy unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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