

Case Number:	CM15-0097843		
Date Assigned:	05/28/2015	Date of Injury:	06/10/2010
Decision Date:	07/02/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/20/2015

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:

The injured worker is a 36-year-old male who sustained an industrial injury on 6/10/10. Injury occurred while he was working in a tile warehouse and picked up a box of tile weighing around 60 pounds. He felt a popping-like sensation and pain in his left shoulder. He underwent left shoulder arthroscopy with SLAP repair, debridement of an undersurface rotator cuff tear, and subacromial decompression on 11/12/10. The 4/13/15 physical therapy progress report indicated that there was persistent global left shoulder stiffness, and the right shoulder felt worse. Physical exam documented right shoulder range of motion as flexion 150, scaption 150, abduction 160, and external rotation 40 degrees in neutral. Functional external rotation was to T3 and internal rotation to T8. There was no documentation of palpatory tenderness or provocative testing of the right shoulder. The 4/20/15 treating physician report cited significantly more right shoulder pain. Prior acupuncture treatment had been helpful in reducing pain and improving range of motion. Physical exam documented positive impingement signs bilaterally, and nonspecific pain and discomfort about the cervical spine and paravertebral muscles. The diagnosis included right shoulder pain due to potential partial rotator cuff tear and secondary adhesive capsulitis. Authorization was requested for right shoulder arthroscopy, rotator cuff repair, subacromial decompression, post-operative physical therapy two times a week for 4 weeks, post-operative ultra-sling and acupuncture therapy times eight for the right shoulder. The 4/29/15 utilization review modified the request for 8 visits of acupuncture for the right shoulder to 6 visits consistent with guideline recommendations. The right shoulder arthroscopy, rotator cuff repair, and subacromial decompression and associated surgical requests was non-certified as there was no imaging evidence of a rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, rotator cuff repair, subacromial decompression: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for impingement syndrome; Surgery for rotator cuff repair.

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, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines for rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment, plus painful arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, rotator cuff or anterior acromial tenderness, and positive impingement sign with a positive diagnostic injection test. Criteria include imaging evidence of a rotator cuff deficit. Guideline criteria have not been met. This injured worker presents with increased right shoulder pain. Clinical exam findings documented limited range of motion and positive impingement testing. However, there was no evidence of abduction weakness, rotator cuff or acromial tenderness, or positive injection test. There was no imaging documented to evidence a surgical lesion. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial directed to the right shoulder and failure has not been submitted. Therefore, this request is not medically necessary.

Post operative physical therapy two times four: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

Post-operative ultra-sling: 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).

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

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

Acupuncture times eight right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Acupuncture Guidelines indicate that acupuncture may be used as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Guidelines state that 3 to 6 treatments allow time to produce functional improvement. Acupuncture treatments may be extended if functional improvement is documented as defined in the guidelines. There is no compelling rationale to support the medical necessity of additional acupuncture prior to assessment of functional improvement with the 6 certified visits. Therefore, this request is not medically necessary.