

Case Number:	CM15-0098023		
Date Assigned:	05/29/2015	Date of Injury:	07/10/2014
Decision Date:	07/07/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/21/2015

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 was a 56-year-old male who sustained an industrial injury on 7/10/14. Injury occurred relative to a motor vehicle accident. He underwent right knee arthroscopic surgery, partial lateral meniscectomy, chondroplasty of the trochlea along with microfracture of the trochlea on 1/15/15. Records indicated that the 4/30/14 left shoulder MRI documented moderate glenohumeral degenerative joint disease with small undersurface tear of the supraspinatus. There was an anterior superior labral tear at the margin. Records indicated that the 8/14/14 left shoulder MRI documented supraspinatus and infraspinatus tendinosis, long head biceps tendinosis, moderate glenohumeral joint degenerative joint disease, and a small inferior posterior labral tear. The 4/15/15 orthopedic report cited continued left shoulder pain with sensation of internal derangement or instability. There was superior, posterior and lateral pain, exacerbated by overhead motion and alleviated by rest. Left shoulder exam documented active forward flexion to 145 degrees, 5/5 strength, external rotation to 60 degrees, and no tenderness to direct palpation. The diagnosis included labral tear of shoulder, AC joint arthropathy, and shoulder osteoarthritis. The injured worker continued to be symptomatic despite corticosteroid injection and physical therapy. Authorization was requested for left shoulder arthroscopy, subacromial decompression, and possible biceps tenodesis versus SLAP repair, versus labral repair, versus rotator cuff repair and AC joint resection as needed, assistant surgeon, physical therapy x 12 visits, cold therapy unit rental x 14 days, and DonJoy UltraSling. The 4/24/15 utilization review non-certified the left shoulder arthroscopic surgery and associated surgical requests as there was

no documentation that conservative treatment had been exhausted, and no clinical impingement signs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy, Subacromial Decompression and Possible Biceps Tenodesis versus SLAP Repair, versus Labral Repair, versus Rotator Cuff Repair and AC Joint Resection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder.

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 SLAP surgery.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. 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. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines (ODG) provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. SLAP surgery is recommended for patients under age 50, otherwise biceps tenodesis is recommended. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have not been met. This injured worker presents with continued left shoulder pain exacerbated by overhead activity. Clinical exam findings documented limited range of motion. There was reported imaging evidence of plausible impingement and labral pathology. However, there were no clinical exam findings relative to positive impingement testing, rotator cuff or anterior acromial tenderness, weakness, or positive diagnostic injection test. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Associated Surgical Service: Assistant Surgeon: 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 Service: Physical Therapy (12-sessions): 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 Service: Cold Therapy Unit (14-day rental): 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) Shoulder: Continuous flow cryotherapy.

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

Associated Surgical Service: DonJoy UltraSling: 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) Shoulder, Postoperative abduction pillow sling.

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