

<b>Case Number:</b>	CM14-0005823		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	06/28/2013
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 49-year-old female sustained an industrial injury on 6/28/13 when she slipped and fell. Past medical history was positive for cervical myelopathy. She is status post C3/4 to C5/6 posterior laminectomy and C4/5 and C5/6 anterior cervical discectomy and fusion on 11/22/11. She is also under care for an L4/5 disc protrusion with moderate narrowing of the mid-line thecal sac and severe narrowing of the right lateral recess. The 8/15/13 initial orthopedic report cited left shoulder pain, exacerbated by overhead activities, and shoulder weakness with numbness and tingling of the left hand. Left shoulder physical exam findings documented no swelling, marked pain to palpation over the anterior aspect of the shoulder, no muscle spasms or atrophy, normal upper extremity sensation, symmetrical shoulder range of motion, and left grip strength weakness. Upper extremity motor strength was 5/5 but for supraspinatus and infraspinatus strength that was 4+/5. Apprehension sign and impingement tests were positive. X-rays of the left shoulder showed some spurring on the undersurface of the acromion. A rotator cuff tear was suspected and an MRI was ordered. The 9/15/13 left shoulder MRI impression documented supraspinatus tendinosis, with approximately 30% partial articular surface tearing of the anterior fibers for about 5mm. There was subscapularis tendinosis, mild degenerative acromioclavicular joint changes with lateral downsloping of the acromion, and a moderate amount of fluid in the subdeltoid bursa. The 9/30/13 progress report noted progressive grade 5-7/10 left shoulder pain. Physical exam findings documented anterior tenderness with stiffness and swelling in the left shoulder, and weakness in internal and external rotation. The left shoulder MRI showed a rotator cuff tear. The treatment plan recommended a diagnostic and operative left shoulder arthroscopy with rotator cuff repair. The 11/21/13 treating physician report indicated the patient was doing poorly with marked left shoulder weakness in external rotation. MRI findings of a large full-thickness rotator cuff tear were noted. The patient had been treated with physical therapy,

injections, medications, and rest, and remained disabled. The treatment plan recommended a diagnostic and operative left shoulder arthroscopy with rotator cuff repair. The 12/16/13 utilization review denied the surgical request based on a lack of imaging to corroborate a full thickness tear, no quantification of weakness, and an inability to ascertain failure of conservative treatment.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **DIAGNOSTIC AND OPERATIVE ARTHROSCOPY FOR LEFT SHOULDER WITH REPAIR OF SMALL ROTATOR CUFF: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Diagnostic arthroscopy, Surgery for rotator cuff repair.

**Decision rationale:** Under consideration is a request for diagnostic and operative left shoulder arthroscopy with rotator cuff repair. The ODG guidelines apply as the patient was less than 90 days status post injury at the time of the original request. 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. Guideline criteria have not been met. There is no detailed documentation that comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried for at least 3 months and had failed. The treating physician report of a full thickness rotator cuff tear is not consistent with the 9/15/13 MRI report that documented a 30% partial thickness tear. There is no clear indication that cervical pathology had been ruled-out. Therefore, this request for a diagnostic and operative left shoulder arthroscopy with rotator cuff repair is not medically necessary.

#### **12 POST OPERATIVE PHYSICAL THERAPY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POSTSURGICAL TREATMENT GUIDELINES, ,

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POST-SURGICAL TREATMENT GUIDELINES, ROTATOR CUFF REPAIR, 27

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

**POST OPERATIVE 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.

**POSTOPERATIVE PAIN PUMP:** 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.

**POST OPERATIVE SHOULDER IMMOBILIZER.:** 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.

**POST OPERATIVE CPM (CONTINUOUS PASSIVE MOTION) MACHINE FOR 2 WEEKS TRAIL:** 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.

**PREOPERATIVE 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.