

Case Number:	CM14-0070931		
Date Assigned:	07/14/2014	Date of Injury:	04/01/2013
Decision Date:	08/13/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/16/2014

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 58-year-old male deputy sheriff sustained an industrial injury on 4/1/13. The patient underwent right shoulder arthroscopic rotator cuff repair and debridement of the posterior superior labral tear on 10/3/13 and completed 22 post-operative physical therapy visits. The patient improved relative to range of motion and lower pain levels, but right shoulder weakness persisted. The 4/14/14 right shoulder MRI impression documented 9.9 mm retraction of the infraspinatus component of the rotator cuff repair with tendinosis and articular surface fraying of the supraspinatus component. There was chronic type 2 SLAP lesion, with degenerative changes of the anterior glenoid rim and anterior inferior labrum. There was mild to moderate acromioclavicular joint arthrosis with hypertrophy and distal subscapularis tendinosis. There was fluid in the extra-articular portion of the biceps tendon. The 4/24/14 treating physician report cited right shoulder pain and weakness. Physical exam documented tenderness over the posterior rotator cuff and biceps tendon within the bicipital groove. Muscle testing documented 4-/5 weakness in external rotation, forward flexion, abduction, and forearm supination. There was pain with resisted biceps testing. Right shoulder range of motion testing documented flexion 150, abduction 150, adduction 50, extension 60, external rotation 90, and internal rotation 60 degrees. Speed's test was positive. Functional limitations were documented with arm use away from body, repetitive push/pull, and overhead use. The patient had failed injections and conservative treatment. The diagnosis was recurrent rotator cuff tear and biceps tendonitis. Surgery was recommended for re-repair of the rotator cuff tear and biceps tenodesis. The 5/5/14 utilization review denied the request for right shoulder surgery and associated services/durable medical equipment based on an absence of documented failure of comprehensive conservative treatment and no evidence of biceps involvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder surgery to re-repair rotator cuff tendon and tenodesis biceps tendon:
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines; Shoulder (Acute & Chronic).

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).

Decision rationale: The ACOEM Guidelines state that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. The Official Disability Guidelines provide specific indications for repair of partial thickness rotator cuff tears and impingement surgery that generally require 3 to 6 months of conservative treatment plus weak or absent abduction, positive impingement sign with a positive diagnostic injection test, and positive imaging evidence of impingement. Guideline criteria have been met. This patient presents with imaging evidence of failure of the rotator cuff repair with 9.9 mm retraction of the infraspinatus tendon, tendinosis and fraying of the supraspinatus tendon, and a SLAP lesion. Functional biceps weakness, positive Speed's, and tenderness suggest a proximal biceps lesion. The patient failed to regain strength with comprehensive conservative treatment. Functional limitations preclude a return to full duty work. Therefore, this request for right shoulder surgery to re-repair rotator cuff tendon and biceps tenodesis is medically necessary.

Abduction sling: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205,213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

Decision rationale: The ACOEM guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines state that abduction slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Given that this is a revision rotator cuff procedure, an abduction sling is reasonable. Therefore, this request for one abduction sling is medically necessary.

Gameready ice machine 10 days: 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 (Acute & Chronic).

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

Decision rationale: The Official Disability Guidelines do not recommend cold compression therapy in the shoulder. The Guidelines state that there are no published studies to support the efficacy of cold compression therapy in the shoulder but indicate it may be an option for other body parts. Continuous flow cryotherapy with a standard cold therapy unit is supported for up to 7 days following shoulder surgery. Guideline criteria have not been met. The use of cold compression therapy is not supported by guidelines, although a standard cold therapy unit would be supported for up to 7 days. Therefore, this request for a Game Ready ice machine for 10 days is not medically necessary.

Post-op Physical Therapy x 8 sessions: Overturned

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

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

Decision rationale: The MTUS Postsurgical Treatment Guidelines for rotator cuff repair/acromioplasty suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. Guideline criteria have been met. Therefore, this request for post-op physical therapy x 8 sessions is medically necessary.