

Case Number:	CM14-0190373		
Date Assigned:	11/21/2014	Date of Injury:	09/21/2011
Decision Date:	01/15/2015	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	11/14/2014

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 is a 53 year old male with a 9/21/11 injury date. A right shoulder MR-arthrogram on 7/23/14 revealed evidence of previous rotator cuff repair, no visible labral tear or biceps anchor pathology, and no visible rotator cuff tear. In a 9/12/14 note, the provider interpreted a deficiency of the leading border of the subscapularis tendon and atrophy of the subscapularis muscle, as well as a superior labral tear, which was not mentioned in the radiology report. In the same note, the patient complained of continued anterior right shoulder pain and restricted motion. Objective findings included right shoulder active elevation to 150 degrees, external rotation to 60 degrees, and internal rotation to the sacroiliac joint. There was pain at the limits of elevation and internal rotation. There were positive impingement tests, difficulty doing the belly press test, and 5-/5 subscapularis strength. Diagnostic impression: Right shoulder pain. Treatment to date: medications, physical therapy, right shoulder rotator cuff repair, injections. A UR decision on 10/20/14 denied the request for right shoulder arthroscopy, labral debridement, possible rotator cuff repair, and possible biceps tenodesis because there was no evidence of conservative treatment failure and there was a discrepancy between the MRI reports and the provider's interpretation. The requests for post-op physical therapy, ultrasling, and cold therapy unit were denied because the associated surgical procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery operative arthroscopy - debridement , trim labrum, possible rotator cuff repair, possible biceps tenodesis, for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Rotator cuff repair, SLAP, biceps tenodesis.

Decision rationale: California MTUS states that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation; conservative treatment of full thickness rotator cuff tears has results similar to surgical treatment, but without the surgical risks, and further indicate that surgical outcomes are not as favorable in older patients with degenerative changes about the rotator cuff. In addition, Official Disability Guidelines (ODG) criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. California MTUS and ODG state that surgery for SLAP lesions is recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved, in addition to a history and physical findings consistent with a SLAP lesion; recent literature suggest poor outcome with a Worker's Compensation patient population and age over 40. California MTUS states that ruptures of the proximal (long head) of the biceps tendon are usually due to degenerative changes in the tendon. It can almost always be managed conservatively because there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, but is not necessary for function. Notably, there was no definite tear of the subscapularis tendon on the MRI. The discrepancy between the provider's interpretation of the MR-arthrogram and the official report would need to be resolved prior to certification of the procedure. In addition, the findings of pain at the extremes of motion, difficulty with internal rotation, and slightly weak subscapularis strength correlate well with the patient's known diagnosis of early glenohumeral arthritis. A full-thickness subscapularis tear would more likely be associated with very weak subscapularis strength, excessive external rotation, positive lift-off sign, and positive belly press sign. These findings were not present. The MR-arthrogram is also the study of choice for diagnosing SLAP tears, and the official report did not mention one. Even if a SLAP tear was present, the evidence-based literature does not view SLAP repair as an effective procedure in patients over the age of 35. On the basis of the above, the medical necessity of the procedure is not supported at this time. Therefore, the request for surgery operative arthroscopy - debridement, trim labrum, possible rotator cuff repair, and possible biceps tenodesis, for the right shoulder is not medically necessary.

Physical Therapy -Post-Op two times a week six weeks QTY:12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: California MTUS supports 40 physical therapy sessions over 16 weeks after rotator cuff repair surgery. However, the associated procedure was not certified. Therefore, the request for physical therapy--post-op two times a week six weeks QTY:12 is not medically necessary.

Durable Medical Equipment - Post -Op ultra sling: 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 Chapter--Postoperative abduction pillow sling.

Decision rationale: California MTUS does not address this issue. Official Disability Guidelines (ODG) recommends abduction pillow slings as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. However, the associated procedure was not certified. Therefore, the request for post-op ultra sling is not medically necessary.

Post -Op 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee Chapter--Continuous-flow cryotherapy.

Decision rationale: California MTUS does not address this issue. Official Disability Guidelines (ODG) states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, the associated procedure was not certified. Therefore, the request for post-op cold therapy unit is not medically necessary.