

<b>Case Number:</b>	CM14-0192291		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	11/06/2013
<b>Decision Date:</b>	01/23/2015	<b>UR Denial Date:</b>	10/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 Minnesota. 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:

The injured worker is a 34-year-old male with a date of injury of 11/6/2013. He reported an injury to the right shoulder while loading pallets and stacking them up. An MRI scan of the right shoulder dated 12/11/2013 revealed mild to moderate rotator cuff tendinosis; possible partial-thickness tear of the distal superior deep margin of subscapularis tendon, possible ganglion of the subscapularis muscle, moderate to severe hypertrophic change of the acromioclavicular joint and slight subacromial and subdeltoid bursitis. The injured worker underwent surgery on March 20, 2014. The operative report indicates the postoperative diagnosis of impingement syndrome, distal clavicle arthrosis, and anterior glenoid labral tear, partial tear of the undersurface of the rotator cuff and subscapularis tendon, right shoulder. The procedure performed consisted of diagnostic and operative arthroscopy with debridement of rotator cuff and glenoid labral tear right shoulder, acromioplasty, and resection of the distal clavicle. The subacromial bursa was debrided. The operative report indicates the finding of a SLAP tear with fraying and fibrillation along the superior border of the subscapularis tendon on the undersurface of the rotator cuff. Grade 2 to grade 3 chondromalacia was noted involving 25% of the head of humerus. Grade 1 to grade 2 chondromalacia involved another 25%. There was impingement from the acromial spur and the distal clavicle. The follow-up orthopedic note dated May 1, 2014 indicates active elevation of the shoulder to 160, abduction 140 and external rotation 45. There was moderate rotator cuff weakness. The impression was resolving impingement syndrome. The plan was to continue physical therapy for modalities, range of motion, and strengthening. On June 9, 2014 there was some persisting pain in the right shoulder with heavy lifting, reaching, and pushing activities. There was occasional pain at night. He was improving with the physical therapy program. Forward flexion was 160 and abduction 150. External rotation was 70 and internal rotation to T10. On 8/1/2014 physical therapy notes indicate completion of 18 visits. On

8/18/2014 20 visits had been completed. A subacromial cortisone injection was given on that day for pain and inflammatory relief. On 9/30/2014 he had completed 30 visits. A follow-up orthopedic examination of 10/6/2014 is noted. There was persisting pain related to heavy lifting. On exam there was some weakness of abduction and external rotation. Range of motion of the shoulder included flexion of 160, abduction 150, external rotation 70 and internal rotation to T12. Impingement testing was negative. There was no tenderness in the bicipital groove. Speed's and Yergason testing for the biceps were negative. Neurologic examination was normal. The diagnosis was status post subacromial decompression, right shoulder with residual loss of range of motion and weakness and persistent pain. On 10/7/2014 the physical therapy notes indicate that he had completed 33 visits. On 10/30/2014 36 visits had been completed. Additional Physical therapy was requested 3 times a week for 4 weeks and an MR arthrogram of the right shoulder was requested on 10/13/2014. Utilization review denied the MR arthrogram of the right shoulder as there was no operative report pertaining to the surgery performed or the date of the procedure. Without knowledge of the procedure completed the guidelines could not be applied for an MR arthrogram of the shoulder. With regard to the request for physical therapy, 3 times a week for 4 weeks, utilization review noncertified the treatment requested as the exact date of the surgical procedure and the operative findings were not known and there was no documentation of the number of physical therapy visits completed postoperatively. However, since that time the additional information has been submitted for this IMR.

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

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

**Additional Physical Therapy three times a week for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99, Postsurgical Treatment Guidelines Page(s): 27. Decision based on Non-MTUS Citation Official Disability Guidelines

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

**Decision rationale:** The documentation indicates completion of 36 physical therapy visits on 10/30/2014, after the surgical procedure of March 20, 2014. The procedure consisted of arthroscopy with subacromial decompression, lateral claviclectomy, and debridement of the rotator cuff and labrum. The postsurgical treatment for this procedure is 24 visits over 14 weeks. The postsurgical physical medicine treatment period is 6 months. The documentation indicates by 10/30/2014 the injured worker had received 36 physical therapy treatments. There is no reason why he could not transition to a home exercise program at that time. In the absence of documentation of continuing objective functional improvement and with the postsurgical period of 6 months having been exhausted, the request for additional physical therapy is not supported by guidelines and as such the medical necessity of this request is not substantiated.

**Arthrography or enhanced CT/MRI shoulder arthrography, injection procedure for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, Table 9-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: MR arthrogram

**Decision rationale:** California MTUS guidelines, table 9-5, page 209, Chapter 9 indicate CT scans for the shoulder to identify pathology of recurrent dislocation, tumor, and infection. However the ability to define pathology is reported as 2 pluses out of 4. The documentation does not indicate suspicion of these conditions. Plain arthrography is recommended to define rotator cuff tears (4+) and has very slight indications in ability to define the pathology of recurrent dislocation or infection (+). MRI scans without arthrography can detect rotator cuff tears (4+) and to a lesser extent tumors (3+) and infections (3+) with some ability to define the pathology of recurrent dislocation (2+) and impingement syndrome (1+). California MTUS guidelines do not address MR arthrography. ODG guidelines are therefore used. The MR arthrogram is recommended as an option to detect labral tears and for suspected recurrent rotator cuff tears after surgery. The injured worker has had an MRI scan without arthrography and also underwent a surgical procedure consisting of subacromial decompression and lateral claviclectomy. The documentation provided, particularly the physical therapy notes document continuing pain since the surgical procedure and continuing complaints related to heavy lifting and reaching activities with minimal nighttime discomfort. Degenerative changes were noted in the glenohumeral joint at the time of arthroscopy with the area of chondromalacia involving 50% of the articular surface of the humeral head. This may explain the continuing shoulder pain. The documentation submitted does not indicate any sudden exacerbation of shoulder pain or limitation of activities warranting additional diagnostic testing such as the requested "arthrography or enhanced CT/MRI shoulder arthrography, injection procedure for right shoulder" from the viewpoint of revision surgery. Good range of motion of the shoulder is documented on examination. The documentation does not report evidence of new physical findings suggestive of recurrent tearing of the rotator cuff or the labrum. MR arthrogram is recommended as an option to detect labral tears and for suspected re-tear postop rotator cuff surgery. MRI is not as good for labral tears. The documentation submitted does not indicate clinical signs suggestive of a labral tear and as such the request for the above listed procedure is not medically necessary.

**Arthrography, radiologic examination for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, Table 9-5.

**Decision rationale:** The guideline rationale for plain arthrography and CT has been discussed. Plain radiographs of the shoulder have very little ability (+) to identify or define pathology such as impingement syndrome, rotator cuff tear, or instability, and slightly greater (++) ability to identify recurrent dislocation, tumor, and infection per MTUS guidelines (Table 9-5, page 209).

The number of +'s indicates relative ability to identify or define pathology. However, plain x-rays would be useful if glenohumeral arthritis is suspected. The request as stated was for an MR arthrogram of the right shoulder. California MTUS guidelines do not address MR arthrography. ODG guidelines are therefore used. The documentation provided, particularly the physical therapy notes document continuing pain since the surgical procedure and continuing complaints related to heavy lifting and reaching activities with minimal nighttime discomfort. Degenerative changes were noted in the glenohumeral joint at the time of arthroscopy with the area of chondromalacia involving 50% of the articular surface of the humeral head. This may explain the continuing shoulder pain. The documentation submitted does not indicate any sudden exacerbation of shoulder pain or limitation of activities warranting additional diagnostic testing from the viewpoint of revision surgery. Good range of motion of the shoulder is documented on examination. The documentation does not report evidence of new physical findings suggestive of recurrent tearing of the rotator cuff or the labrum. MR arthrogram is recommended as an option to detect labral tears and for suspected re--tear postop rotator cuff surgery. MRI is not as good for labral tears. The documentation submitted does not indicate clinical signs suggestive of a labral tear and as such the request for an MR arthrogram is not supported. The documentation also does not support indications for other requests including enhanced CT, and plain arthrography, and the request is not medically necessary.