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| Case Number: | CM14-0202322 | | |
| Date Assigned: | 12/12/2014 | Date of Injury: | 10/30/2007 |
| Decision Date: | 02/06/2015 | UR Denial Date: | 11/18/2014 |
| Priority: | Standard | Application Received: | 12/03/2014 |

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 53-year-old female with a reported date of injury of 10/30/2007. The documentation indicates presence of right shoulder impingement and rotator cuff tear diagnosed on the basis of an unofficial ultrasound study. A full-thickness rotator cuff tear with 2 cm retraction was diagnosed on the right side. A full-thickness tear of the left rotator cuff with 1.5 cm retraction was also noted. The primary treating physician's medical legal report dated December 22, 2014 refers to the utilization review denial of the November 18, 2014 request for arthroscopy of the right shoulder with subacromial decompression, distal clavicle resection and rotator cuff repair along with preoperative medical clearance, supervised postoperative physical therapy 34, home CPM device for 45 days, Surgi Stim unit for 90 days, and cold care cold therapy unit. Per documentation submitted, patient is on opioids for pain control and reports a pain level of 6-8/10. She has recently completed 24 sessions of physical therapy to the neck and shoulder. On examination there was tenderness to palpation. A crepitus was noted with range of motion. Flexion of the right shoulder was 110, extension 38, abduction 95, internal rotation 57, and external rotation 38. Diagnostic ultrasound study dated August 15, 2014 revealed a large full-thickness tear of the right supraspinatous tendon with retraction, fibrosis, and adhesions, subscapularis tendon disruption/degeneration; tear of the right long head of biceps tendon, and large tear of the anterior superior glenoid labrum and biceps anchor complex and advanced cartilaginous fragmentation and avulsion from the glenoid rim. Impingement testing was positive bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic right shoulder evaluation, arthroscopic subacromial decompression, distal clavicle resection and rotator cuff repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211 and 214.

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) Section: Shoulder, Topic: Diagnostic ultrasound

Decision rationale: California MTUS guidelines indicate surgical considerations for patients who have activity limitation for more than 4 months plus existence of a surgical lesion and failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion. Clear clinical and imaging evidence of a lesion that has been shown to benefit, and both the short and long term, from surgical repair is an indication for surgical considerations. With regard to the ultrasound examination, ODG indicate diagnostic ultrasound is recommended when performed by specialists for the detection of full-thickness rotator cuff tears. Ultrasound may be better at picking up partial tears. Ultrasound is more cost effective in a specialist hospital setting for identification of full-thickness tears. It is also highly accurate imaging study for evaluating the integrity of the rotator cuff in shoulders that have undergone an operation. The clinical picture as described correlates with the ultrasound findings and there has been a failure to increase the range of motion and strength despite a recent exercise program. The rotator cuff tear is full thickness and is reported to be significantly retracted and therefore surgery is warranted. The preferred procedure is arthroscopic decompression which involves debridement of inflamed tissue, subacromial decompression, resection of the lateral clavicle and a rotator cuff repair. There is documented evidence of impingement and the subacromial decompression is indicated. The utilization review denial was based upon lack of information with regard to a failed rehabilitation program. This has since been provided. The denial was also based upon the unofficial ultrasound results. The official report has since been provided. The request is medically necessary.

Pre-operative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Low back, Topic: Preoperative testing

Decision rationale: California MTUS guidelines do not address this topic. ODG are therefore used. Preoperative testing is necessary in the presence of comorbidities. The ODG indicate arthroscopy is a low risk procedure. Per available documentation, review of systems is positive for depression, stress, anxiety, thyroid resection, and use of opioids. Past surgical history is

remarkable for anterior cervical discectomy and fusion, and a right brachial plexus exploration. However, there is no history of hypertension, diabetes, or cardiac disease or renal disease. Based upon the above the guidelines do not recommend routine medical clearance. A history and physical examination performed by the attending physician is part of the surgery package. The request is not medically necessary.

Supervised post-operative rehabilitative therapy, three times weekly for four weeks:
Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The Postsurgical Treatment Guidelines indicate 24 visits over 14 weeks for impingement syndromes/rotator cuff syndrome and for a rotator cuff repair/acromioplasty. The postsurgical physical medicine treatment period is 6 months. The guidelines indicate an initial course of therapy of 12 visits. With documentation of continuing objective functional improvement a subsequent course of therapy of 12 visits may be prescribed within the above parameters. The requested 12 visits are within the guidelines and as such the medical necessity is established.

Home continuous passive motion (CPM) device for an initial period of 45 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 (ODG), Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, topic: Continuous passive motion

Decision rationale: The guidelines do not recommend use of continuous passive motion for rotator cuff repairs. It is suggested as an option for adhesive capsulitis. As such, the request for continuous passive motion machine is not supported and the 45 day rental requested is not supported by guidelines and is not medically necessary.

Sturgi-stim unit for an initial period of ninety days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114 - 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation, interferential current stimulation Page(s): 118, 121.

Decision rationale: Chronic pain guidelines do not recommend interferential current stimulation and neuromuscular electrical stimulation after surgery. ICS is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications and limited evidence of improvement on those recommended treatments. Findings from trials were either negative or non-interpretable for recommendation due to poor study design and or methodologic issues. Neuromuscular electrical stimulation is primarily used following stroke and there is no evidence to support its use in chronic pain. It is not recommended postoperatively. As such, the request for Surgi Stim rental for 90 days is not supported by guidelines and the medical necessity is not established.

Coolcare cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, topic: Continuous flow cryotherapy

Decision rationale: Per guidelines, continuous-flow cryotherapy is recommended as an option after shoulder surgery for 7 days. It reduces pain, swelling, inflammation, and need for narcotic medications in the postoperative period. Rental for 7 days is recommended. However, the request as stated does not specify rental or purchase and also does not specify the length of the rental. Therefore the request as stated is not supported by guidelines and the medical necessity is not established.