

<b>Case Number:</b>	CM14-0202852		
<b>Date Assigned:</b>	01/28/2015	<b>Date of Injury:</b>	04/21/2014
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	11/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 61-year-old female with right shoulder pain. Date of injury was 4/21/2014. Mechanism of injury was a fall. The worker was exiting the freezer going into the cutting room when she tripped over some containers. An MRI scan of the right shoulder dated 7/7/2014 revealed moderate supraspinatus tendinosis, superimposed healing changes associated with a 1 cm cyst at the musculotendinous junction of the infraspinatus. A partial-thickness tearing affected 50% of the thickness of the tendon. Moderate acromioclavicular arthritis was noted. The treatment to date has included 17 sessions of physical therapy since 4/22/2014, medications, cortisone injection. 1. The injured worker also received acupuncture which seemed to relieve her headaches but did not help the shoulder. Exam noted range of motion of 80/80/50 with positive impingement signs. Request for surgery submitted on 11/10/14 included arthroscopic subacromial decompression, rotator cuff repair and debridement and possible Mumford procedure. Physical therapy notes dated January 23, 2015 indicate approval of 6 additional treatments. She stated that she was wearing her sling to work. On January 26, 2015 she continued to be in a tremendous amount of pain and was unable to perform range of motion exercises without causing increased pain. The provider's notes dated January 15, 2015 indicate a pain level of 9-10/10 in the right shoulder. She had completed 17 physical therapy sessions. She also completed 20 authorized acupuncture sessions in total. She had increased pain after each physical therapy session. Right shoulder flexion was 65, extension 25, adduction 20, abduction 60, internal rotation 40 and external rotation 40. Impingement signs were positive and there was a positive apprehension test. There was tenderness to palpation over the anterior shoulder joint

and the superior margin of the scapula. The disputed issue pertains to the request for surgery as above. This was non-certified by utilization review as the conservative treatment had not been exhausted. However, since that time additional information has been received and the issue appealed to an IMR.

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

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

**Arthroscopic subacromial decompression, rotator cuff repair and debridement and possible Mumford procedure:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, and 211..

**Decision rationale:** California MTUS guidelines indicate surgical considerations for 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 and clear clinical and imaging evidence of a lesion that has been shown to benefit, and both the short and long-term from surgical repair. The worker has evidence of a partial-thickness rotator cuff tear associated with impingement syndrome and acromioclavicular arthritis of the right shoulder. She has had an adequate trial of conservative treatment since April 2014 using corticosteroid injection as well as 17 physical therapy treatments. She is not responding to an active rehabilitation program because of continuing pain which is reported to be relatively severe. The degree of pain prevents an adequate home exercise program. She is using a sling at work which is likely causing muscle atrophy and additional weakness and stiffness of the shoulder. She has limited range of motion of the shoulder and evidence of impingement on examination. Surgery for impingement syndrome is arthroscopic decompression. The procedure is indicated in patients who have relatively severe symptoms and associated activity limitations as in this case. There is failure of an exercise rehabilitation program to improve the range of motion and function in the shoulder. There is MRI evidence of impingement associated with a partial-thickness rotator cuff tear. There has been a satisfactory trial/failure of nonoperative treatment since April 2014. Therefore the guideline criteria have been met and the medical necessity of the requested surgical procedure is established. The home exercise program has not been effective due to pain associated with range of motion exercises.

**Pre-operative clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Section: Low Back, Topic: Pre-operative testing, general, Pre-operative lab testing. Preoperative testing, Electrocardiography.

**Decision rationale:** California MTUS does not address this issue. ODG guidelines are therefore used. The decision for pre-operative testing and consultations should be guided by the patient's clinical history, comorbidities, and physical examination findings. Arthroscopic ambulatory orthopedic procedures are considered low risk and routine testing is not necessary. The documentation provided does not include a detailed history of co-morbidities and rationale for pre-operative clearance are not submitted. Guidelines suggest a thorough history and physical examination and appropriate work-up and consultations if co-morbidities are discovered. As such, the medical necessity of a pre-operative clearance is not substantiated.

**Post-operative pain pump: 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, Section: Shoulder, Topic: Post-operative pain pump.

**Decision rationale:** California MTUS guidelines do not address this issue. ODG guidelines are therefore used. ODG guidelines are therefore used. ODG guidelines do not recommend the use of pain pumps in shoulder surgery. As such, the request for a post-operative pain pump is not supported and the medical necessity is not substantiated.

**Post-operative cold unit for thirty 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 and Knee Chapters

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Section: Shoulder, Topic: Continuous flow cryotherapy

**Decision rationale:** California MTUS guidelines do not address this issue. ODG guidelines are therefore used. Continuous flow cryotherapy is recommended as an option after shoulder surgery. The general use is for a maximum period of 7 days. It reduces pain, swelling, inflammation, and reduces the need for post-operative narcotics for pain control. The request as stated is for 30 days and is not supported by guidelines. As such, the medical necessity of this request is not substantiated.

**Post-operative interferential unit for sixty days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Section.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

**Decision rationale:** California MTUS chronic pain guidelines do not recommend the use of interferential current stimulation as an isolated intervention. There is no quality evidence of effectiveness. As such, the request for a post-operative interferential unit for 60 days is not supported by guidelines and the medical necessity of this request is not substantiated.

**Post-operative continuous passive motion unit for sixty days:** 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 Section: Shoulder, Topic: Continuous passive motion

**Decision rationale:** California MTUS does not address this issue. ODG guidelines are therefore used. ODG guidelines do not recommend the use of continuous passive motion after subacromial decompression and rotator cuff surgery. As such, the request for post-operative continuous passive motion unit for 60 days is not supported and the medical necessity is not substantiated.

**Post-operative ultra-sling for sixty days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82 - 88.

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

**Decision rationale:** California MTUS guidelines indicate shoulder disorders lead to joint stiffness more often than other joint disorders. If indicated the joint can be kept at rest in a sling. However, gentle exercise is desirable and rigid immobilizers are not necessary particularly after arthroscopic subacromial decompression and partial thickness rotator cuff repair. Although a standard sling is appropriate, the medical necessity of the ultra-sling for 60 days is not established.

**Post-operative physical therapy, twice weekly for four weeks:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27, 10, 11.

**Decision rationale:** The Postsurgical Treatment guidelines recommend 24 visits over 14 weeks for rotator cuff syndrome/ impingement syndrome. The postsurgical physical medicine treatment period is 6 months. The initial course of therapy is one half of these visits which is 12 visits. The request as stated is for 8 visits which is within the guidelines and is appropriate and medically necessary.

**Norco 10/325 mg, sixty count:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82 - 88, 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications Page(s): 124.

**Decision rationale:** The documentation provided indicates use of hydrocodone for several months and so weaning is necessary. The worker will be scheduled for surgery and the request is for Norco for postoperative pain control during the rehabilitation process. This seems appropriate and weaning will be necessary in the postoperative period. The request as stated for Norco is therefore medically necessary to allow for weaning.