

Case Number:	CM14-0205749		
Date Assigned:	12/18/2014	Date of Injury:	02/16/2012
Decision Date:	02/13/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/09/2014

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 51 year old female with a 2/16/12 injury date. A 4/26/14 right shoulder MRI revealed a partial thickness tear in the distal supraspinatus tendon with no definite full-thickness tear, significant cuff tendinosis, and acromioclavicular (AC) joint arthritis. In a 10/17/14 note, the patient complained of right shoulder pain and weakness. Objective findings included tenderness over the right shoulder, AC joint, subacromial space, and joint. There were positive impingement signs, 4/5 strength, and slightly reduced active range of motion. Diagnostic impression: right shoulder partial-thickness rotator cuff tear and AC joint arthritis. Treatment to date: medications, physical therapy, and injections. A UR decision on 11/18/14 denied the request for right shoulder arthroscopy, subacromial decompression (SAD), distal clavicle excision (DCE), and rotator cuff repair/debridement but the rationale was not present. The requests for pre-op medical clearance, post-op physical therapy, continuous passive motion (CPM) device, SurgiStim unit, and cold therapy unit were denied because the associated surgical procedures were not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, distal clavicle resection and rotator cuff debridement and/or repair: Overturned

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

Guidelines (ODG); Surgery Chapter, Impingement syndrome, Indications for Surgery, Acromioplasty, Shoulder Chapter, Surgery for Rotator Cuff Repair Section.

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): Shoulder Chapter--Surgery for impingement syndrome, Rotator cuff repair, distal claviclectomy.

Decision rationale: CA 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, ODG criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. ODG supports partial claviclectomy (including Mumford procedure) with imaging evidence of significant AC joint degeneration along with physical findings (including focal tenderness at the AC joint, cross body adduction test, active compression test, and pain reproduced at the AC joint with the arm in maximal internal rotation may be the most sensitive tests), and pain relief obtained with an injection of anesthetic for diagnostic purposes. Non-surgical modalities includes at least 6 weeks of care directed towards symptom relief prior to surgery including anti-inflammatories and analgesics, local modalities such as moist heat, ice, or ultrasound. CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. In this case, there appears to be enough evidence to support going forward with the proposed surgery. The patient has objective and imaging evidence of significant rotator cuff disease, including a partial-thickness tear with severe tendinosis and weakness on exam. In this setting, the possibility of a small full-thickness tear is difficult to exclude. The patient has a history of appropriate treatment for impingement syndrome and AC joint arthritis that has not been very helpful. There is also sufficient evidence on both exam and imaging for impingement syndrome and AC joint arthritis. A surgical procedure that evaluates the rotator cuff and repairs a full-thickness tear if present, and debrides the cuff if no such tear is present, is appropriate at this point. In addition, an SAD and DCE are appropriate to address the symptoms coming from impingement and AC joint arthritis. Therefore, the request for right shoulders arthroscopic evaluation. Arthroscopic subacromial decompression, distal clavicle resection and rotator cuff debridement and/or repair are medically necessary.

Associated Surgical Services: Pre-Operative medical clearance: Overturned

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 Other Medical Treatment Guideline or Medical

Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for non-cardiac surgery.

Decision rationale: CA MTUS does not address this issue. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for non-cardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. Given the patient age of 51 and the approval of the associated procedures, the request for a pre-op medical evaluation is appropriate. Therefore, the request for pre-operative medical clearance is medically necessary.

Associated Surgical Services: Supervised post-operative rehabilitative therapy; 12 sessions (3x4): 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Surgery for impingement syndrome, Rotator cuff repair.

Decision rationale: CA MTUS and ODG support a maximum of 24 physical therapy sessions over 14 weeks after surgery for impingement syndrome and rotator cuff repair. Given the approval of the associated procedures, the request for post-op physical therapy is appropriate. Therefore, the request for supervised post-operative rehabilitative therapy; 12 sessions (3x4), is medically necessary.

Associated Surgical Services: Home continuous passive motion (CPM) device for initial period of 45 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 Official Disability Guidelines (ODG): Shoulder Chapter, CPM.

Decision rationale: CA MTUS does not address this issue. ODG does not consistently support the use of CPM in the postoperative management of rotator cuff tears; but CPM treatment for adhesive capsulitis provides better response in pain reduction than conventional physical therapy. However, there is no evidence that this patient has symptoms of adhesive capsulitis, and the evidence-based literature does not support the routine use of CPM after surgery for rotator cuff issues. Therefore, the request for home continuous passive motion (CPM) device for initial period of 45 days is not medically necessary.

Associated Surgical Services: SurgiStim unit for initial period of 30 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-118.

Decision rationale: CA MTUS explains that the SurgiStim unit incorporates interferential, NMS/EMS, and galvanic therapies into one unit. However, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. In addition, CA MTUS does not consistently recommend interferential, NMS, and galvanic electrotherapy. Therefore, the request for SurgiStim unit for initial period of 30 days is not medically necessary.

Associated Surgical Services: Coolcare cold therapy unit: Overturned

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: CA MTUS does not address this issue. 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. Given the approval of the associated shoulder procedure, the post-op use of a cold therapy unit is appropriate, but only for a 7-day rental of the unit. Therefore, the request for Coolcare cold therapy unit is medically necessary.