

Case Number:	CM15-0148481		
Date Assigned:	08/11/2015	Date of Injury:	12/16/2010
Decision Date:	09/23/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	07/30/2015

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: Illinois, California, Texas
 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:

This injured worker is a 67-year-old male who sustained an industrial injury on 12/16/10, due to cumulative trauma. Past medical history was positive for history of Hepatitis C and hypertension. Past surgical history was positive for bilateral shoulder surgeries in 2012. Conservative treatment had included physical therapy, medication, activity modification, off work, and chiropractic treatment. The 6/19/15 left shoulder MR arthrogram impression documented a slightly limited study to the large amount of metallic susceptibility artifacts near the supraspinatus tendon footprint. There was a 2 cm focal full thickness tendon defect with slight interval increase in the amount of medial retraction (2.2 cm), partially visualized again at the footplate of the posterior two thirds of the supraspinatus tendon. There was interval development of a 1 cm moderate grade partial thickness intrasubstance delaminating tear in the superior and middle insertional fibers of the subscapularis tendon. A diminutive and diffusely frayed superior glenoid labrum is present, which could be due to a combination of prior labral tear and surgical debridement. There was minimal tenosynovitis of the long head of the biceps tendon. The 7/9/15 treating physician report cited grade 6/10 left shoulder pain, worse with activities. Left shoulder exam documented left abduction 140 degrees, internal/external rotation 60 degrees, positive impingement tests, and 4/5 weakness in flexion, abduction and external rotation. Updated left shoulder MRI showed a 2 cm rotator cuff tear, retracted 2 cm, and there was essentially no atrophy in the muscle bellies. The injured worker had a re-tear of the left shoulder with no atrophy, it was still reparable. He had failed physical therapy and medications. Authorization was requested for outpatient reconstruction of chronic complete rotator cuff avulsion including acromioplasty, pre-operative medical clearance, post-op physical therapy 12

sessions, cryotherapy unit with pain, and shoulder sling purchase. The 7/24/15 utilization review non-certified the outpatient reconstruction of chronic complete rotator cuff avulsion including acromioplasty and associated surgical requests as there were positive exam and imaging findings but it was not clear if these findings represented a change from surgery to the shoulder performed in 2012. Clarity with respect to conservative care and current indications was needed to determine the medically necessary of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Reconstruction of complete shoulder rotator cuff avulsion, Chronic (includes acromioplasty): 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), Shoulder - Rotator cuff repair.

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: Surgery for Impingement syndrome; Surgery for rotator cuff repair.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery and rotator cuff surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines for rotator cuff repair with a diagnosis of full thickness tear typically require clinical findings of shoulder pain and inability to elevate the arm, weakness with abduction testing, atrophy of shoulder musculature, usually full passive range of motion, and positive imaging evidence of rotator cuff deficit. Guideline criteria have been met. This injured worker presents with persistent and function-limiting left shoulder pain. Clinical exam findings are consistent with imaging evidence of a full thickness rotator cuff tear. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Pre-operative medical clearance: 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), Low back - Preop testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient age, co-morbidities, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Post operative physical therapy 12 sessions: 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 California MTUS Post-Surgical Treatment Guidelines for impingement syndrome and rotator cuff repair suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.

Associated surgical service: Cryotherapy unit with pad: 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.

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

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

Associated surgical service: Shoulder sling purchase: 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), Shoulder - Postop abduction pillow.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205 and 213.

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.