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| Case Number: | CM15-0161255 | | |
| Date Assigned: | 08/28/2015 | Date of Injury: | 09/30/2010 |
| Decision Date: | 09/30/2015 | UR Denial Date: | 07/23/2015 |
| Priority: | Standard | Application Received: | 08/18/2015 |

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 9/30/10. The mechanism of injury was not documented. Past medical history was positive for a heart attack. He underwent left shoulder arthroscopic subacromial decompression in April 2011, and a left shoulder arthroscopy with subacromial decompression and lysis of adhesions status post rotator cuff repair on 9/25/13. Conservative treatment included activity modification, medications, independent gym exercise, and psychotherapy. The 6/2/15 left shoulder MRI impression documented attenuation of the distal fibers of the supraspinatus tendon suggesting re-tearing of the tendon. A full thickness tear could not be excluded. There was moderate grade tearing of the infraspinatus tendon. Findings documented moderate to severe atrophy of the infraspinatus and mild atrophy of the supraspinatus tendon. There were prior surgical changes relative to the rotator cuff tendon repair, subacromial decompression, and resection of the distal clavicle. The 7/16/15 treating physician report cited worsening grade 4/10 left shoulder pain, localized laterally over the deltoid region. Pain was better with medication, and worse with left shoulder activity and at night. Left shoulder range of motion testing documented flexion 130, abduction 100, and external rotation 40 degrees with 5-/5 supraspinatus and external rotation weakness. There was tenderness to palpation over the lateral acromion and deltoid space. There was recurrent pain after two shoulder surgeries. A diagnostic injection test was performed with 50% relief of pain and improvement in active range of motion to 160 degrees abduction and 170 degrees flexion with mild anterior pain at extremes of motion. The diagnosis included left rotator cuff tendinitis, and recurrent left shoulder rotator cuff tear. Authorization was requested for left

shoulder arthroscopy with possible revision rotator cuff repair with decompression, and post-operative physical therapy twice a week for four weeks. The 7/23/15 utilization review non-certified the left shoulder arthroscopy with possible revision rotator cuff repair and decompression with post-op physical therapy as there was no updated imaging or detailed recent conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy possible Revision Rotator Cuff Repair with Decompression: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Diagnostic arthroscopy; Surgery for rotator cuff repair; Surgery for impingement syndrome.

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 rotator cuff repair.

Decision rationale: The California MTUS guidelines provide a general recommendation for partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines provide more specific indications for partial thickness rotator cuff repairs that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement or rotator cuff deficiency. Guideline criteria have been met. This injured worker presents with persistent and function-limiting right shoulder pain. Clinical exam findings are consistent with imaging evidence of rotator cuff deficiency. There was documentation of a positive diagnostic injection test. Evidence of a reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Post-operative physical therapy 2 x 4 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 California MTUS Post-Surgical Treatment Guidelines for 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.