

Case Number:	CM15-0190207		
Date Assigned:	10/07/2015	Date of Injury:	05/12/2011
Decision Date:	12/14/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/28/2015

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 54-year-old female who sustained an industrial-work injury on 5/12/11. The mechanism of injury was not documented. She underwent right shoulder rotator cuff repair surgery in 2014. Conservative treatment had included physical therapy, corticosteroid injections, medications, activity modification, and home exercise program. The 6/12/15 right shoulder MR arthrogram revealed evidence of changes in the supraspinatus tendon likely representing a partial thickness tear at the distal insertion anterior fibers. There was an interval development of a delaminating interstitial partial thickness tear, humeral insertion of the infraspinatus tendon. The 7/13/15 treating physician report cited continued right shoulder pain despite surgical intervention and post-operative physical therapy. She complained of weakness, decreased range of motion, inability to lift more than 2 pounds, frequent spasms, fatigue with activity, and depression regarding her decreased quality of life. She complained of constant sharp right shoulder pain. Pain worsened with any increased activity and weakness precluded above shoulder level work. She also reported left shoulder pain from overcompensating and difficulty sleeping due to pain. She had not returned to work. Right shoulder exam documented global 4/5 right shoulder weakness. Right shoulder range of motion was documented as painful with abduction 140, forward flexion 150, adduction 20, extension 15, and internal/external rotation 70 degrees. Apley scratch, supraspinatus, and impingement tests were positive. Referral to the orthopedic surgeon was planned. The 9/8/15 treating physician report cited continued shoulder pain. The last two steroid injections did not provide any pain relief. Physical therapy helped but there was still pain. Physical exam documented painful arc of motion starting at 90 degrees, forward

flexion 180 degrees with difficulty, adduction 30 degrees, normal external rotation, and internal rotation to the back pocket. There was 4/5 forward flexion and external rotation weakness. Impingement and cross arm tests were positive. The diagnosis included rotator cuff tear. Authorization was requested for right shoulder revision, rotator cuff repair with allograft augmentation and associated surgical services including post-op physical therapy 2x6, abduction orthosis sling, and cold therapy unit rental x 3 weeks. The 9/15/15 utilization review non-certified the right shoulder revision, rotator cuff repair with allograft augmentation and associated surgical requests as there was no documentation of painful active arc of motion, pain at night, loss of abduction, or outcome of the anesthetic injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder revision, rotator cuff repair with allograft augmentation: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition, 2015, Shoulder (Acute & Chronic)/Surgery for Rotator Cuff Repair.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. 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 rotator cuff surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. 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 right shoulder pain and weakness. There was significant functional difficulty noted that interfered with activities of daily living and precluded return to work. Clinical exam findings are consistent with imaging evidence of a rotator cuff deficiency. Detailed evidence of up to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Post-op physical therapy 2xwk x 6wks for the right shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

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. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.

Associated surgical services: Abduction orthosis sling for the right shoulder: 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), Treatment Index, 13th Edition, 2015, Shoulder (Acute & Chronic)/Postoperative abduction Pillow Sling.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Activity Modification, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Postoperative abduction pillow sling.

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines state that post-operative abduction pillow slings, are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. An arthroscopic rotator cuff repair is planned for a partial thickness tear. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request is not medically necessary.

Associated surgical services: Cold therapy unit for the right shoulder (rental x 3 weeks): 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), Treatment Index, 13th Edition, 2015, Shoulder (Acute & Chronic)/Continuous-flow cryotherapy.

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. Guidelines generally recommend the at-home use of cold packs. 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 3 weeks rental which is not consistent with guidelines. Therefore, this request is not medically necessary.