

Case Number:	CM15-0193552		
Date Assigned:	10/07/2015	Date of Injury:	03/03/2013
Decision Date:	12/17/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/01/2015

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: California

Certification(s)/Specialty: Orthopedic Surgery, Hand Surgery, Sports Medicine

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 70 year old male who sustained a work-related injury on 3-3-13. Medical record documentation on 9-15-15 revealed the injured worker was being treated for large retracted rotator cuff tear with supraspinatus and infraspinatus atrophy and acromioclavicular joint arthrosis. He reported two hours of pain relief of the left shoulder following a cortisone injection. He noted no improvement with physical therapy, home exercise program, and Tylenol. Objective findings included atrophy of the supraspinatus and infraspinatus muscles. His left shoulder passive range of motion was 90-60-60 with pain and guarding. His active range of motion was limited to 30 degrees of flexion and he had tenderness of the acromioclavicular joint. Impingement sign was positive. He had no rotator cuff weakness and he had pain with abduction and external rotation testing. A request for left shoulder acromioplasty, Mumford, possible rotator cuff repair, manipulation under anesthesia and associated services was received on 9-22-15. On 9-29-15, the Utilization Review physician determined left shoulder acromioplasty, Mumford, possible rotator cuff repair, manipulation under anesthesia and associated services was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder acromioplasty, Mumford, possible rotator cuff repair, manipulation under anesthesia: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder - Manipulation under anesthesia (MUA).

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Campbell's Operative Orthopaedics, 11th ed. Chapter 44, Shoulder and Elbow Injuries.

Decision rationale: This is a request for shoulder surgeries. In this case, I have greater information available and recommend overturning the utilization review decision. The patient is a 70-year-old man with a large retracted full thickness superior rotator cuff tear with muscle atrophy diagnosed by August 20, 2013 MRI. Upon initial consultation with the treating surgeon on September 30, 2013, the surgeon noted, "I explained to him that I do not feel his rotator cuff is repairable based on the atrophy and degree of retraction." Nonsurgical treatment was recommended and performed including supervised therapy, independent exercise, acetaminophen, ibuprofen and two documented injections which were briefly helpful. Symptoms are persistent with pain, markedly decreased motion, weakness and atrophy noted on examination. The patient now elects to proceed with surgery. Surgical options including debridement and reverse shoulder arthroplasty have been discussed; the patient elects to proceed with debridement. The California MTUS notes that impingement and rotator cuff tendinopathy are, "a continuum, from mild supraspinatus tendon degeneration to complete ruptures (page 210)." This individual is at the severe end of the spectrum with a complete tear which will not be surgically repairable. However, the proposed treatment of decompression and debridement in this setting has been effective in achieving pain relief; such treatment is beyond the scope of the California MTUS guidelines, but discussed in the specialty text referenced. The acromioplasty is the standard decompression above the torn rotator cuff mentioned in the CA MTUS guidelines on page 211. The Mumford procedure is designed for concurrent treatment of acromioclavicular joint arthrosis. The proposed manipulation is in an effort to help the patient achieve better motion. As noted by the treating surgeon in 2013 the rotator cuff tear was probably not repairable at that point it is almost certainly not repairable now, but intra-operative assessment of the rotator cuff is standard and the most definitive way to assess the possibility of repair the requested possible rotator cuff repair reflects that standard surgical assessment. Therefore, in this individual with a massive rotator cuff tear, acromioclavicular joint arthrosis and substantial shoulder stiffness, which is persistently symptomatic despite years of non-surgical treatment with medications, therapy and multiple injections, the proposed surgery is medically necessary and appropriate.

Post-op physical therapy x 12 visits: Overturned

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

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

Decision rationale: This is a request for therapy following surgical treatment for a large complete rotator cuff tear. The most appropriate guidelines are those on page 27 of the California MTUS guidelines, which would support up to 40 therapy sessions over 16 weeks following surgery for complete rupture of the rotator cuff. An initial course of treatment is defined as half that number of visits with additional therapy being appropriate if there were functional improvement with the initial course as defined on page one of the Guidelines. This request for 12 post-surgical sessions is consistent with the guidelines and is determined to be medically necessary.

Cold therapy unit and immobilizer: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation J Shoulder Elbow Surg. 2015 Mar 27. pii: S1058-2746(15)00077-4. doi: 10.1016/j.jse.2015.02.004. [Epub ahead of print] Compressive cryotherapy versus ice-a prospective, randomized study on postoperative pain in patients undergoing arthroscopic rotator cuff repair or subacromial decompression. Kraeutler MJ1, Reynolds KA2, Long C2, McCarty EC2.

Decision rationale: This is a request for a commercial cold therapy unit to be used following shoulder surgery. Commercial cold therapy units have not been shown to improve outcomes and are not included in any evidence based treatment guidelines such as the California MTUS. There is no medical evidence that such units improve outcomes following the proposed surgery when compared to cooling with readily available materials such as bags of ice. The study referenced above compared commercial cold compression units to bags of ice and found no benefits of the cold therapy units. With no medical evidence that the cold therapy unit would be effective, it is determined to be unnecessary. Slings and immobilizers are often used briefly following the proposed surgery, although long-term use is not recommended and is counter to the goal of achieving better shoulder motion. In this case, the cold therapy unit is unnecessary and therefore the combined request including the cold therapy unit is not medically necessary.

Post-op Norco 7.5 #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation J Hand Surg Am. 2012 Apr;37(4):645-50. doi: 10.1016/j.jhsa.2012.01.035. Epub 2012 Mar 10. Opioid consumption following outpatient upper extremity surgery. Rodgers J1, Cunningham K, Fitzgerald K, Finnerty E. 1Des Moines Orthopaedic Surgeons, P.C., West Des Moines, IA 50265, USA. jrodgers@dmos.com.

Decision rationale: This is a request for 100 7.5 mg Norco tablets. Norco is a DEA scheduled II narcotic with, "high potential for abuse which may lead to severe psychological or physical dependence." Use of narcotics to manage post-operative pain is reasonable, but the requested 100 7.5 milligram tablets is excessive. The amount of narcotic appropriately prescribed following such surgery is beyond the scope of the California MTUS guidelines, but was evaluated in the peer reviewed study referenced which noted, "our data show that excess opioid analgesics are made available after elective upper extremity surgery and could potentially become a source for diversion. A prescription of 30 opioid pills for outpatient surgery appears excessive and unnecessary." Therefore, this request for 100 tablets is not medically necessary.