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| Case Number: | CM15-0218457 | | |
| Date Assigned: | 11/10/2015 | Date of Injury: | 01/22/2013 |
| Decision Date: | 12/23/2015 | UR Denial Date: | 10/13/2015 |
| Priority: | Standard | Application Received: | 11/06/2015 |

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 58-year-old male who sustained an industrial injury on 1/22/13. The mechanism of injury was not documented. Past medical history was positive for diabetes. He underwent right shoulder arthroscopic debridement of the rotator cuff, subacromial decompression, and distal clavicle resection on 11/13/14, without improvement over time or with therapy. Post-operative conservative treatment included activity modification, medications, physical therapy, home exercise, and corticosteroid injection. The 6/1/15 right shoulder MRI impression documented a partial thickness attachment site tearing of the supraspinatus tendon with shallow articular surface tearing of the distal supraspinatus. He was status post Mumford procedure. There was subacromial subdeltoid bursal effusion. A type II acromion and lateral down-sloping of the acromion were noted. Records documented the corticosteroid injection on 6/3/15 provided with 3 days of relief with no sustained change in range of motion and he reported persistent locking-up of the shoulder. The 8/26/15 treating physician report noted continued right shoulder pain with limited range of motion and quick fatigue. He was performing a home exercise program. He was now on insulin for his diabetes. Physical exam documented point tenderness over the anterior greater tuberosity and some tenderness along the biceps groove. There were positive impingement signs, and weakness with resistance. Continued exercise for 6 more weeks was recommended. The 10/6/15 treating physician report cited persistent right shoulder pain with motion, and scapular spasms. He did not feel like he had made any progress with therapy. Post-operative MRI showed some changes in the supraspinatus consistent with partial tear/tendinosis but no full thickness tearing. Right shoulder exam

documented continued anterior diffuse shoulder, and significant tenderness over the biceps groove. He had full passive range of motion but had only 90 degrees of active elevation and abduction. External rotation was 45 degrees with internal rotation to T12. There was pain at all end-ranges. Diabetes was felt to be affecting his healing potential and better diabetic control would be helpful. He wanted to proceed with revision surgery given his current level of symptoms and inability to return to work. Authorization was requested right shoulder scope bicep tenotomy and revision acromioplasty with associated surgical requests for hot/cold compression unit with shoulder wrap for 30 days and Don Joy cradle. The 10/13/15 utilization review modified the request for right shoulder scope bicep tenotomy and revision acromioplasty to a right shoulder arthroscopy with revision subacromial decompression and rotator cuff debridement as there was no imaging evidence of biceps tenosynovitis. The request for hot and cold compression unit with shoulder wrap for 30 days was modified to 7 days consistent with guidelines. The request for a Don Joy cradle was modified to a generic cradle sling.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder scope bicep tenotomy and revision acromioplasty: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Acromioplasty; Surgery for impingement syndrome; Surgery for SLAP repair.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. 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 (ODG) for acromioplasty require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. The ODG generally recommend biceps tenotomy for revision SLAP surgery and with associated large rotator cuff repair in older patients. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have been met. This injured worker presents with persistent right shoulder pain with significant loss of active range of motion. Functional difficulty precludes his ability to return to work. Clinical findings are consistent with imaging evidence of partial thickness rotator cuff tears and plausible impingement. Diagnostic arthroscopy provides definitive diagnosis of SLAP lesions. Occult biceps tears, incomplete and MRI-negative, are often confirmed at time of arthroscopic surgery. The 10/13/15 utilization review modified this request to right shoulder arthroscopy with revision subacromial decompression and rotator cuff debridement. It is reasonable to include biceps tenotomy at the surgeon's discretion based on findings at the time of arthroscopy. Therefore, this request is medically necessary.

Associated surgical services: Hot/cold compression unit with shoulder wrap times 30 days:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, 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: Cold compression therapy; Continuous flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold compression therapy. The Official Disability Guidelines do not recommend cold compression therapy in the shoulder but state that continuous-flow cryotherapy is an option for up to 7 days. Guidelines state that there is no evidence of improved clinical post-operative outcomes for patients using an active cooling and compression device over those using ice bags and elastic wrap after upper extremity surgery. The 10/13/15 utilization reviews this request for hot/cold compression unit with shoulder wrap for 30 day rental to a 7-day rental. There is no compelling reason presented to support the medical necessity of a hot/cold compression unit in the absence of guideline support for cold compression therapy and beyond the current certification. Therefore, this request is not medically necessary.

Associated surgical services: Doy Joy cradle: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Activity Modification, Summary.

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. The 10/13/15 utilization review modified this request from a Don Joy cradle to a generic cradle sling. There is no compelling reason to support the medical necessity of one specific cradle sling over another. Therefore, this request is not medically necessary.