

Case Number:	CM15-0035349		
Date Assigned:	03/03/2015	Date of Injury:	04/24/2007
Decision Date:	04/17/2015	UR Denial Date:	02/22/2015
Priority:	Standard	Application Received:	02/25/2015

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

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 66-year-old female who reported an injury on 04/24/2007. The mechanism of injury was the injured worker tripped over a client's walker and fell forward onto her outstretched arms. The diagnosis included left shoulder strain, acromioclavicular joint arthritis with right shoulder strain/impingement, rotator cuff tear, cervical trapezial musculoligamentous strain and sprain with lumbar musculoligamentous strain and sprain, left lateral epicondylitis, elbow with left thumb metacarpophalangeal joint sprain, strain bilateral knee contusion with patellofemoral arthralgia. The documentation indicated the injured worker underwent a left shoulder arthroscopy and Mumford procedure on 09/22/2009. The injured worker underwent an ultrasound on 05/07/2008 and had a surgery on the right shoulder in 1995. The injured worker underwent an MRA of the right shoulder, which revealed a full thickness tear of the supraspinatus of at least 2.2 cm of torn fiber retraction with proximal atrophy and free communication of contrast to the subacromial/subdeltoid and subcoracoid bursa. There was supraspinatus tendinosis and a high-grade articular surface tear and anteriorly with fatty atrophy of the muscle belly. There was subscapularis tendinosis. There was intrasubstance contrast signal likely related to arthrographic approach. There was intra-articular biceps tenodesis. There was glenohumeral joint arthritis including focally advanced chondral denudation of the superior surface of the humeral head and marginal osteophyte formation. There was superior labral degeneration. There was AC joint osteoarthrosis osseous fragmentation. There was contour irregularity of the distal clavicle that may be remotely post-traumatic in nature from healed trauma with eburnation of the acromion due to rotator cuff tear. The documentation of

11/10/2014 revealed the injured worker had persistent symptoms despite all attempts at aggressive conservative management. The physical examination revealed decreased range of motion of the bilateral shoulders. The injured worker had severe supraspinatus tenderness, mild greater tuberosity tenderness, mild biceps tenderness, and mild biceps tendon tenderness. The injured worker's strength was 4/5 in flexion, abduction, and internal and external rotation. The injured worker had painful range of motion. Testing was affected by pain. The injured worker had a positive AC joint compression test, impingement 1, impingement 2, and impingement 3 tests on the right. The injured worker had a positive impingement 2 and 3 test on the left. The injured worker underwent an MR arthrogram of the right shoulder revealing a full thickness supraspinatus tear at least 2.2 cm of retraction with proximal atrophy. The diagnosis included MRI scan confirmed right rotator cuff repair 09/10/2014 status post industrial trip and fall incident at work 04/24/2007. The treatment plan included a right shoulder arthroscopic evaluation, revision, subacromial decompression, distal clavicle resection, and rotator cuff repair as indicated. There was a Request for Authorization submitted dated 11/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopic revision, subacromial decompression, distal clavicle resection and rotator cuff repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: The American College of Occupational and Environmental Medicine indicate that surgical consultation may be appropriate for injured workers who have activity limitation for more than 4 months, failure to increase range of motion and strength in the musculature around the shoulder, even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. In regard to impingement syndrome, and rotator cuff repair, this procedure is not indicated for injured workers with mild symptoms and those who had no activity limitations. Conservative care, including cortisone injections, should be carried out for at least 3 to 6 months before considering surgery. There should be documentation of a deficit in the rotator cuff. They do not specifically address distal clavicle resection. As such, secondary guidelines were sought. The Official Disability guidelines indicate that a distal clavicle resection is recommended for the diagnosis of post-traumatic arthritis of AC joint and there should be documentation of conservative care of at least 6 weeks plus pain at the AC joint and pain with shoulder motion and objective findings of tenderness over the AC joint plus imaging findings of post traumatic changes of the AC joint. The clinical documentation submitted for review failed to indicate the injured worker had conservative care. However, the injured worker was noted to have a full thickness tear of the supraspinatus with at least 2.2 cm of torn fiber retraction and was noted to have a high-grade articular surface tear anteriorly. The injured worker was noted to have glenohumeral joint arthrosis and AC joint arthrosis. As such, conservative care would not be

necessary. These findings would not respond to conservative care. As such, the request for a Right Shoulder Arthroscopic revision, subacromial decompression, distal clavicle resection and rotator cuff repair is medically necessary.

Standard pre-op medical clearance: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, low back section, Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.choosingwisely.org/?s=preoperative+surgical+clearance&submit=.

Decision rationale: Per the Society of General Internal Medicine Online, "Preoperative assessment is expected before all surgical procedures." The clinical documentation submitted for review supported the surgical intervention. As such, a standard pre-op medical clearance is appropriate.

Associated surgical service: 2 night home sleep study (Polyosomnogram) to rule out sleep apnea: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, pain section, Polysomnography.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Polysomnography.

Decision rationale: The Official Disability Guidelines indicate that polysomnography is recommended after at least 6 months of insomnia complaints of at least 4 nights per week and that the injured worker has been unresponsive to behavioral interventions and sedative/sleep promoting medications and after psychiatric etiology has been excluded. There was a lack of documented rationale for the necessity for a polysomnogram. There was a lack of documentation indicating the injured worker had 6 months of an insomnia complaint and was unresponsive to behavior interventions and sedative/sleep promoting medications and psychiatric etiology had been excluded. As such, the request for associated surgical service: 2-night home sleep study (polyosomnogram) to rule out sleep apnea is not medically necessary.

Supervised Post-Op Physical Therapy 3 times a week for 4 weeks right shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California Medical Postsurgical Treatment Guidelines indicate that the physical therapy treatment for rotator cuff syndrome is 24 visits and the initial therapy is half the recommended number of visits, which would equal 12. The surgical intervention was found to be medically necessary. As such, the request for supervised post-op physical therapy 3 times a week for 4 weeks right shoulder is medically necessary.

Associated surgical service: Home Continuous Passive Motion (CPM) device for an initial period of 45 days: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, shoulder section, Continuous passive motion (CPM).

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

Decision rationale: The Official Disability Guidelines indicate that continuous passive motion is recommended for adhesive capsulitis. The injured worker was not noted to have adhesive capsulitis. There was a lack of documentation of exceptional factors. As such, this request would not be supported. Given the above, the request for associated surgical service: home continuous passive motion (CPM) device for an initial period of 45 days is not medically necessary.

Associated surgical service: Surgi-Stim Unit for an Initial period of 90 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS. NMES. Interferential Current Stimulation. Galvanic Stimulation Page(s): 114 - 116, 121, 118, 117.

Decision rationale: The California Medical Treatment Utilization Schedule recommend a TENS unit for the treatment of postoperative pain for 30 days. They do not recommend Neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its use in chronic pain. They do not recommend Interferential Current Stimulation (ICS) as an isolated intervention. Galvanic Stimulation is not recommended. 90 days would exceed the guideline recommendations. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the body part to be treated. Given the above, the request for associated surgical service: surgi-stim unit for an initial period of 90 days is not medically necessary.

Associated surgical service: Coolcare Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, shoulder section, 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 Chapter, Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines recommend a continuous flow cryotherapy unit for 7 days. The request as submitted failed to indicate the duration of use and whether the unit was for rental or purchase and the body part to be treated. There was a lack of documentation of exceptional factors. Given the above, the request for associated surgical service: Coolcare cold therapy unit is not medically necessary.