

<b>Case Number:</b>	CM15-0039910		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	02/15/2012
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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: Minnesota, Florida

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 67-year-old male, who sustained an industrial injury on 02/15/2012. He has reported subsequent shoulder, wrist, back and knee pain and was diagnosed with rotator cuff tears, bilateral carpal tunnel syndrome, lumbosacral strain/arthrosis, degenerative arthrosis of knees and possible ongoing medial meniscal tears. Treatment to date has included oral pain medication, physical therapy, home exercise program and surgery consisting of a rotator cuff repair of the left shoulder and debridement of the labrum and biceps tendon. Examination notes of December 22, 2014 indicate the injured worker was 4 months status post left shoulder surgery. Initially he did well. However, lately he had increased pain in the shoulder which was noticed by his therapist. He was now on a home exercise program which was not helping. Physical examination showed a markedly positive Neer's and Hawkins Kennedy sign. There was supraspinatus weakness. He felt a click with supraspinatus testing. The pain was all lateral. The diagnosis was: Left shoulder status post prior arthroscopic labral, bicipital, and subscapularis debridements, chondroplasty of the glenoid, subacromial decompression, and PASTA rotator cuff repair. An MR arthrogram was scheduled. The MR arthrogram was performed on 2/6/2015 and showed the prior rotator cuff repair with a single suture anchor seen in the superolateral aspect of the humeral head. There was increased signal including gadolinium signal seen extending across nearly the entire footprint of the repair and across nearly the entire cuff repair about 1 cm from its attachment with moderate subacromial/subdeltoid gadolinium containing bursal fluid indicating full-thickness perforation of the rotator cuff repair. However, there was no evidence of retraction. There was moderate to severe underlying tendinosis of

the remaining infraspinatus tendon noted. Moderate degenerative changes of the acromioclavicular joint were noted. A superior labral tear from anterior to posterior without significant displacement was noted. There was moderate to severe tendinosis of the long head of the biceps tendon. Severe muscle atrophy of teres minor tendon and mild to moderate interstitial tearing of the superior fibers of the subscapularis tendon. The request for left shoulder arthroscopic rotator cuff repair and treatment of other pathologies was modified by utilization review to a rotator cuff repair using California MTUS guidelines. The remaining surgical request was nonspecific and was modified. The request for preoperative medical clearance was modified to include CBC and basic metabolic panel. The request for postoperative physical therapy 2 x 6 was certified. The request for purchase of a cold therapy unit with pad and sterile cold therapy wrap was modified to a 7 day rental of the cold therapy unit and purchase of the pad and sterile cold therapy wrap. Additional requests for a sling and abduction pillow were certified. The modified requests have now been appealed to an independent medical review. Documentation indicates that the surgical procedure was performed on March 6, 2015. The postoperative diagnosis was a recurrent rotator cuff tear. The procedure performed included examination under anesthesia and arthroscopic revision of rotator cuff repair.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Treatment of other pathologies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211.

**Decision rationale:** The request as stated for other pathologies was nonspecific and as such, the medical necessity of the remaining surgical requests could not be determined. The guidelines criteria cannot be applied if there is no definite surgical plan. As such, the medical necessity of the remaining requests for correction of other pathologies cannot be determined.

**Associated surgical services: Purchase of cold therapy unit, pad, sterile cold therapy wrap:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Procedure.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

**Decision rationale:** ODG guidelines recommend continuous flow cryotherapy as an option after surgery. It reduces pain, swelling, and inflammation and the need for narcotics after surgery.

The recommended use is for 7 days after surgery including home use. Purchase of the pad and wrap is necessary to use the unit and is appropriate. The request as stated is for purchase of the cold therapy unit which is not supported by guidelines and as such the medical necessity of the request has not been substantiated.