

Case Number:	CM15-0046257		
Date Assigned:	03/18/2015	Date of Injury:	04/30/2003
Decision Date:	05/01/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/11/2015

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:

The injured worker is a 69 year old male who sustained an industrial injury on 4/30/03. The mechanism of injury was not documented. He underwent a rotator cuff repair in July 2004. The 2/2/15 treating physician report cited persistent left shoulder problems. He had pain with reaching and was unable to do any type of heavy lifting or perform activities at or above shoulder level comfortably. He had pain at night. Physical exam documented active range of motion limited to shoulder level and below, with normal passive range of motion. There were 4-/5 strength, 1+ tenderness over the acromioclavicular joint, and no instability. Radiographs of the left shoulder demonstrated moderate proximal humeral migration and a retained anchor in the greater tuberosity. There was no glenohumeral joint space narrowing. There may have been previous resection of the distal clavicle. The diagnosis was left shoulder probable large to massive rotator cuff tear. The previous MRI demonstrated a great deal of artifact secondary to the anchor in the greater tuberosity. Repeating the MRI would be of little benefit. The injured worker had been under care since 2012 for this left shoulder problem. He had not responded to conservative measures. Given the persistent nature of his symptoms and failed conservative treatment, authorization was requested for left shoulder arthroscopy, possible debridement, possible foreign body removal, possible revision rotator cuff repair, possible bicep tenodesis, possible revision subacromial decompression and assistant surgeon, a cold therapy unit 14-day with pad, ultra-sling with pillow, and post-op physical therapy 2 times a week for 6 weeks. The 2/17/15 utilization review denied the request for left shoulder arthroscopic surgery, assistant surgeon, post-op cold therapy unit, post-op Ultrasling, and post-op physical therapy as there was

no imaging evidence available documenting a rotator cuff tear to support the medical necessity of surgery at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy, possible debridement, possible foreign body removal, possible revision rotator cuff repair, possible bicep tenodesis, possible revision subacromial decompression and assistant surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder Complaints, Acromioplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for rotator cuff repair; Surgery for impingement syndrome.

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 rotator cuff tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines for rotator cuff repair with a diagnosis of full thickness tear typically require clinical findings of shoulder pain and inability to elevate the arm, weakness with abduction testing, atrophy of shoulder musculature, and positive imaging evidence of rotator cuff deficit. Guideline criteria have not been met. The patient presents with persistent function-limiting left shoulder pain. Clinical exam documented active range of motion limited to shoulder level and below, 4-/5 weakness, and acromioclavicular joint tenderness. X-rays documented moderate proximal humeral migration with retained anchor in the greater tuberosity. However, there is no current imaging evidence to support the diagnosis of large or massive rotator cuff tear. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Associated surgical services: Cold Therapy Unit Rental x 14 days with pad ultra-sling with pillow: 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); Shoulder, continuous flow cryotherapy, Knee Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling; Continuous flow cryotherapy.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Post-op Physical Therapy 2 x6: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 17 and 27.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.