

Case Number:	CM15-0058750		
Date Assigned:	04/17/2015	Date of Injury:	03/18/2014
Decision Date:	07/07/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	03/27/2015

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 55-year-old female who sustained an industrial injury on 3/18/14. Injury occurred when she fell from a chair onto her left arm and shoulder. Past surgical history was positive for left shoulder arthroscopy with posterior labral repair, subacromial decompression, and biceps tenodesis on 3/12/13. The 11/21/14 left shoulder MRI impression documented stable post-surgical changes for labral repair, biceps tenodesis, and sub-clavicular resection. There was stable supraspinatus and infraspinatus tendinopathy with a small focal tear in the supraspinatus. The 2/18/15 treating physician report cited persistent left shoulder pain when she was not taking anti-inflammatories. She had a corticosteroid injection with temporary relief. Physical exam documented functional range of motion, 5/5 supraspinatus stress test with pain, 5/5 external rotation stress test, 5/5 belly press and lift off, and negative Hawkin's and Neer test. Imaging documented a high-grade partial thickness tear of the conjoined tendon, probably interstitial but with extension to the bursal surface. There was stable adjacent moderate tendinosis. The diagnosis was status post left shoulder surgery, now with partial rotator cuff tear status post fall. Symptoms had plateaued. The treatment plan recommended Rotational Medical patch arthroscopic placement to solidly heal the tear and remodel the surrounding tendinosis. The injured worker was to return to work without restrictions until surgery. The 3/19/15 utilization review non-certified the left shoulder arthroscopy and associated surgical requests based on no documentation of medical necessity, supported by high-quality medical evidence based guidelines to justify this request. The 4/15/15 treating physician report cited left shoulder pain interfering with activities of daily living. She was working with considerable pain, but was

worried that she would be fired if she did not work. She had a severe left rotator cuff tear that was worsening over time. She was found to have significant rotator cuff tendinosis but no frank tear at the time of her previous surgery. The tear clearly occurred when she fell. Severe tendinosis makes the rotator cuff tendon more like to tear and re-tear. For this reason, the Rotation Medical patch is medically necessary, as it has been shown to remodel the rotator cuff tendinosis into healthy tissue.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy: Upheld

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

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; Graft, rotator cuff.

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 rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment, plus painful arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, rotator cuff or anterior acromial tenderness, and positive impingement sign with a positive diagnostic injection test. Criteria include imaging evidence of a rotator cuff deficit. The ODG indicate that rotator cuff grafts are under study. Over the past few years, many biologic patches have been developed to augment repairs of large or complex rotator cuff tendon tears. These patches include both allograft and xenografts. Regardless of their origins, these products are primarily composed of purified type I collagen. There is a lack of studies demonstrating which ones are effective. Guideline criteria have not been met. This patient presents with persistent left shoulder pain when not taking her anti-inflammatories. There was imaging evidence of a small partial thickness rotator cuff tear. There is no documentation of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure. Clinical exam findings documented functional range of motion, full strength, and negative impingement testing. Given the absence of clinical findings and lacking guideline support for the requested procedure, the medical necessity of this request cannot be established. Therefore, this request is not medically necessary.

Associated Surgical Service: Medical Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: Physical Therapy (12 sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: UltraSling: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.