

Case Number:	CM14-0093451		
Date Assigned:	08/04/2014	Date of Injury:	01/17/2012
Decision Date:	09/16/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/19/2014

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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

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 52-year-old female sustained an industrial injury on 1/17/12. Injury occurred when she slipped and fell off a shuttle bus, landing on her right side with onset of neck and shoulder pain. The patient underwent right shoulder arthroscopic rotator cuff repair on 4/26/13 and was also diagnosed with cervical disc disease. The 7/30/13 right shoulder MRI impression documented postsurgical changes from acromioplasty and distal clavicle excision. There was moderate supraspinatus tendinosis/tendinitis with subtle postsurgical irregularity and/or fraying. Findings were consistent with moderate to marked, worsening infraspinatus tendinosis/tendinitis with possible interstitial tearing, including delamination of some of the superficial tendon fibers and possible subtle extension of the tear to the bursal surface. There was mild to moderate subscapularis tendinosis/tendinitis, moderate to marked subacromial/subdeltoid bursitis, and moderately large effusion within the bursa. The 5/9/14 treating physician report cited persistent significant right anterior shoulder pain. Right shoulder physical exam documented significant pain with elevation, abduction and external rotation to 80 degrees, significant pain down the anterior arm and with palpation over the biceps tendon in the bicipital groove. There was a defect in the deltoid. There was positive impingement and acromioclavicular joint tenderness. The patient had had several cortisone injections that helped fairly significantly for about one week. Right shoulder arthroscopy with debridement, repair of the deltoid and possible biceps tenodesis was recommended. The 6/5/14 utilization review certified a request for right shoulder diagnostic scope with debridement and open repair of the deltoid. The request for 24 post-operative physical therapy visits was modified to 12 initial visits consistent with guidelines. Records documented a palpable defect of the biceps from the prior open rotator cuff surgery. The patient had undergone months of physical therapy without any improvement. There was difficulty with overhead activities and significant pain with supraspinatus testing and O'Brien's.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder arthroscopy with Debridement: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pmc/Articles/PMC2219931/>;

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

Decision rationale: The California MTUS 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 show 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. Guideline criteria have been met. The patient presents with significant anterior shoulder pain, markedly limited abduction, pain over the biceps tendon in the bicipital groove, and positive impingement testing. The right shoulder MRI showed worsening of tendinosis with partial tearing of the rotator cuff, and worsening subacromial bursitis with a moderately large effusion. Comprehensive non-operative treatment has been tried and failed. Therefore, this request for right shoulder arthroscopy with debridement is medically necessary.

Open Repair of Deltoid: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines: Deltoid.

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

Decision rationale: The California MTUS 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 show to benefit, in the short and long-term, from surgical repair. Guideline criteria have been met. The patient presents with a defect in the deltoid status post rotator cuff repair. Physical exam documented abduction and external rotation to 90 degrees, significant anterior shoulder pain, and positive impingement testing. Imaging documented worsening tendinosis and partial rotator cuff tearing. There was worsening subacromial bursitis and a moderately large effusion. Comprehensive non-operative treatment has been tried and failed. Therefore, this request for open repair of the deltoid is medically necessary.

Possible Biceps Tenodesis: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Biceps Tendon Repair, <http://www.ncbi.nlm.nih.gov/pubmed/17210420>.

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

Decision rationale: The California MTUS 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 show to benefit, in the short and long-term, from surgical repair. Guideline criteria have been met. The patient presents with imaging findings of a partial rotator cuff tear and significant pain with palpation over the bicipital groove. Comprehensive conservative treatment has been tried and has failed. Occult biceps tears, incomplete and MRI-negative, are often confirmed at the time of arthroscopic surgery. Therefore, this request for possible biceps tenodesis is medically necessary.

Twenty four (24) Physical Therapy Visits for Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post Surgical Treatment Guidelines.

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for rotator cuff repair suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 6/5/14 utilization review recommended partial certification of 12 initial post-operative physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of additional care. Therefore, this request for twenty four (24) Physical Therapy Visits for Right Shoulder is not medically necessary and appropriate.

Sling: Overturned

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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213.

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. Therefore, this request for one shoulder sling is medically necessary.

Cryotherapy: 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): 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, Continuous flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. Guidelines would support simple cold packs. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery. Postoperative use generally may be up to 7 days, including home use. The use of a simple cold pack or the use of a cold therapy unit for 7 days post-operatively would be supported. However, this request is for an unknown item or length of use which is not consistent with guidelines. Therefore, this request for cryotherapy is not medically necessary.

Ancef 1 gm IV (Intravenous): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Antibiotic Prophylaxis for arthroscopy of knee <http://www.ncbi.nlm.nih.gov/pubmed/17214020>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Working Group of the Clinical Practice Guideline for the Patient Safety at Surgery Settings. Clinical practice guideline for the patient safety at surgery settings. (AIAQS); 2010. 191 p.

Decision rationale: The California MTUS and Official Disability Guidelines do not address the use of prophylactic antibiotics in the peri-operative course or post-operative course. Clinical practice guidelines indicate that a single standard dose of antibiotic is sufficient for prophylaxis in most circumstances, except if surgery that longer than four hours or if loss of blood exceeds 1500 cc. Guideline criteria have been met. Therefore, this request for Ancef 1 gm IV (Intravenous) is medically necessary.

General Anesthesia: Overturned

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 Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

Decision rationale: This patient is recommended to undergo a right shoulder arthroscopy with debridement, open deltoid repair, and possible biceps tenodesis. General anesthesia is the standard of care for this procedure. Therefore, this request for general anesthesia is medically necessary.