

<b>Case Number:</b>	CM14-0217695		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	08/25/2009
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/29/2014

### 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. 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, Sports Medicine

### 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 60-year-old female who reported an injury on 08/25/2009. The mechanism of injury was a slip and fall. Her diagnoses include right full thickness rotator cuff tear. The injured worker past treatments have included physical therapy, medications and psychiatric treatments. Diagnostic studies include an unofficial ultrasound performed on 08/27/2014, which revealed a large full thickness supraspinatus rotator cuff tear with 1.5 cm, but no atrophy of the muscle belly or fatty infiltration; and an official neurological testing of the bilateral upper extremities performed on 08/18/2014, which revealed no electrical evidence of bilateral cubital or carpal tunnel syndrome, no electrical evidence of a cervical radiculopathy or brachial plexopathy affecting the C5-T1 lower motor fibers of the bilateral upper extremities or the cervical paraspinals; no electrical evidence of a generalized peripheral neuropathy affecting the upper extremities. Her surgical history was noncontributory. The injured worker presented on 10/27/2014 with complaints of persistent right shoulder pain, tenderness, stiffness and weakness. She reports her current pain level is 7/10. Upon physical examination of the bilateral shoulders, range of motion upon forward flexion was at 160 degrees bilaterally, extension was at 40 degrees bilaterally, abduction was at 160 degrees bilaterally, adduction was at 40 degrees bilaterally, external rotation was at 90 degrees bilaterally and internal rotation was at 60 degrees bilaterally. Tenderness to palpation of the supraspinatus was severe. Tenderness to palpation of the greater tuberosity was moderate. Tenderness to palpation upon the biceps tendon was mild. Tenderness to the pectoralis major muscle was negative. Acromial joint tenderness was noted to be moderate bilaterally and subacromial crepitus was present bilaterally. Motor strength was

noted to be 4/5 bilaterally. Neurologic and sensation testing was noted to be intact bilaterally with the exception of decreased sensation in the entire bilateral hands and fingers. The injured worker had a positive AC joint compression test bilaterally on passive forward flexion and slight internal rotation a positive impingement 2 test bilaterally. Passive internal rotation with 90 degrees of flexion and a positive impingement 3 test bilaterally with 90 degrees active abduction with a classic painful arc. Her current medication regimen was not provided within the medications submitted for review. The treatment plan included a right shoulder arthroscopic evaluation, arthroscopic rotator cuff debridement and distal clavicle resection. A request for postoperative therapy 3 times per week for 4 weeks, authorization for home continuous passive motion device and postoperative use of a SurgiStim unit for an initial period of 90 days and a Coolcare cold therapy unit. After the benefit of use of 90 days, then purchase for the unit would be recommended. The rationale for the request is that the injured worker is an excellent candidate for the surgery and understands, as she has been explained the options, and wishes to proceed. A Request for Authorization form dated 10/27/2014 was provided within the documentation submitted for review.

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

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

**Arthroscopic evaluation, arthroscopic rotator cuff debridement and distal clavicle resection:** Upheld

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

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

**Decision rationale:** The request for arthroscopic evaluation, arthroscopic rotator cuff debridement and distal clavicle resection is not medically necessary. The injured worker has right shoulder pain. The California ACOEM Guidelines state that referral for surgical consultation may be indicated for patients who have: Red flag conditions; activity limitations for more than 4 months, plus existence of a surgical lesion; failure to increase in range of motion and strength even after exercise program; with the existence of a surgical lesion; and clear clinical and imaging evidence of a lesion. The guidelines state that if surgery is a consideration, counseling is very important. Additionally, rotator cuff repair is indicated by tears that impair activities with arm elevation, particularly in younger workers. The documentation submitted for review provided evidence that the injured worker has failed physical therapy and medications. However, the documentation failed to include evidence of psychological counseling in regard to the arthroscopic debridement and distal clavicle resection in order to determine if the injured worker was a good candidate for this particular surgery and failed to provide evidence that overhead activities were limited. In the absence of the aforementioned documentation, the request, as submitted, is not medically necessary.

**Associated surgical service: Pre-operative 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Preoperative testing, general.

**Decision rationale:** The request for preoperative medical clearance is not medically necessary. The injured worker has right shoulder pain. The Official Disability Guidelines recommend general preoperative testing, which is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices and guide postoperative management. The documentation submitted for review failed to support the medical necessity for the arthroscopic evaluation, arthroscopic rotator cuff debridement and distal clavicle resection. As the request for the surgery was found not to be medically necessary, the request for preoperative medical is not supported. As such, the request for preoperative medical clearance is not medically necessary.

**Associated surgical service: Supervised post-operative rehabilitative therapy. 12 sessions:** Upheld

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

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

**Decision rationale:** The request for supervised postoperative rehabilitative therapy 12 sessions is not medically necessary. The injured worker has right shoulder pain. The California MTUS Postsurgical Treatment Guidelines recommend 24 postoperative physical therapy visits for a rotator cuff. The documentation failed to provide evidence to support the medical necessity for the arthroscopic rotator cuff debridement and distal clavicle resection. Given that the surgery was found to be not medically necessary, the postoperative rehabilitative therapy is not supported by the guidelines. As such, the request for supervised postoperative rehabilitative therapy 12 sessions is not medically necessary.

**Associated surgical service: Continuous passive motion (CPM) device for an initial period of fourteen (14) days:** 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 passive motion (CPM).

**Decision rationale:** The request for continuous passive motion device for an initial period of 14 days is not medically necessary. The injured worker has right shoulder pain. The Official Disability Guidelines do not recommend continuous passive motion for shoulder rotator cuff problems, but recommend as an option for adhesive capsulitis up to 4 weeks/5 days per week. The documentation submitted for review failed to provide evidence to support the request for an arthroscopic rotator cuff debridement and distal clavicle resection. Additionally, as the guidelines do not recommend the use of continuous passive motion for rotator cuff problems, the request is not supported. As such, the request for continuous passive motion device for an initial period of 14 days is not medically necessary.

**Associated surgical service: Surgi-stim unit for an initial period of ninety (90) days, then purchase:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

**Decision rationale:** The request for SurgiStim unit for an initial period of 90 days then purchase is not medically necessary. The injured worker has right shoulder pain. The California MTUS recommends a 1 month trial period of a TENS unit should be documented as an adjunct to ongoing treatment modalities with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; and rental would be preferred over purchase during this trial. The documentation submitted for review failed to provide evidence to warrant the need for an arthroscopic rotator cuff debridement and distal clavicle resection. Additionally, the request, as submitted, exceeds the guideline recommendation of an initial 1 month trial. Given the above, the request for SurgiStim unit for an initial period of 90 days then purchase is not medically necessary.

**Associated surgical service: Coolcare 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:** The request for Coolcare cold therapy is not medically necessary. The injured worker has right shoulder pain. The documentation submitted for review failed to provide evidence to warrant the medical necessity for an arthroscopic rotator cuff debridement and distal clavicle resection. As the surgery was found not to be medically necessary, the Coolcare cold therapy unit is not warrant. As such, the request for Coolcare cold therapy is not medically necessary.

