

<b>Case Number:</b>	CM14-0030490		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	10/23/2009
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	02/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2014

### 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 Orthopedic 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 is a 53 year old male with a 10/23/09 injury date. The injury to the right shoulder occurred while taking a tire off a car. In a 1/31/14 ortho consult note, the patient complained of constant right shoulder pain, decreased motion, and pain that wakes him up at night. There is a history of two previous surgeries by a different provider since his 2009 injury. Both were for rotator cuff tear and both were not successful. Objective findings included right shoulder healed surgical incisions, no Tinel's, elevation to 90 degrees, active assist elevation to 100 degrees, external rotation to neutral with small lag, able to do a belly press, internal rotation to the buttocks, barely able to do a lift-off, and good radial pulse. A 2012 right shoulder MRI was reviewed by the provider and showed a full-thickness supraspinatus tear with complete atrophy of the muscle belly and fatty infiltration. The provider diagnosed him with an irreparable rotator cuff tear and recommended a latissimus dorsi transfer. Diagnostic impression: right shoulder massive rotator cuff tear. Treatment to date: right shoulder surgery x 2, medications, physical therapy. A UR decision on 2/20/14 denied the request for right latissimus transfer with one to two day inpatient length of stay because there were no imaging studies available for review. The requests for pre-op medical clearance, post-op cold therapy unit, post-op physical therapy, Percocet, Oxycontin, and Colace were denied because the associated surgical procedure was not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Latissimus Transfer with one to two day Inpatient Length of Stay: 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 Warner JJ. Management of Massive Irreparable Rotator Cuff Tears: the role of tendon transfer. Instr Course Lect 50: pages 63-71, 2001.

**Decision rationale:** CA MTUS and ODG do not address shoulder tendon transfers. Warner JJ stated that the main indication for latissimus dorsi tendon transfer is an irreparable, massive, postero-superior rotator cuff tear in a patient with intolerable shoulder pain and subjectively unacceptable dysfunction. In this case, the patient has imaging evidence of a retracted cuff tear with fatty atrophy, failure of two previous rotator cuff repairs, an age that prohibits a reconstructive surgery such as a reverse shoulder prosthesis, significant weakness and functional impairment on exam, and failure of conservative treatment. A latissimus dorsi transfer would be appropriate. CA MTUS does not address the issue of hospital length of stay. ODG supports a 2 day hospital stay after total shoulder arthroplasty. Given that a latissimus dorsi transfer is an open procedure of similar complexity, a 1-2 day inpatient stay would be appropriate. Therefore, the request for Right Latissimus Transfer with one to two day Inpatient Length of Stay is medically necessary.

**Pre-Operative Medical Clearance:** 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 ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery

**Decision rationale:** CA MTUS and ODG do not address this issue. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. Given the patient's age of 53 and the certification of the associated procedure, a pre-op medical evaluation is appropriate. Therefore, the request for Pre-Operative Medical Clearance is medically necessary.

**Post-Operative Fourteen Day Rental of Vasumtherm Cold Therapy Unity:** 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), Knee Chapter-Continuous-Flow Cryotherapy.

**Decision rationale:** CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, the guidelines only support a 7-day rental and the current request is for a 14-day rental. Therefore, the request for Post-Operative Fourteen Day Rental of Vascutherm Cold Therapy Unit is not medically necessary.

**Post-Operative Physical Therapy to the Right Shoulder, two times a week over six weeks:**  
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 Chapter-Physical therapy.

**Decision rationale:** CA MTUS does not address this issue. ODG supports 24 physical therapy sessions over 10 weeks after shoulder arthroplasty. Since the current request is for 12 total sessions over 6 weeks, the request can be certified. Therefore, the request for Post-Operative Physical Therapy to the Right Shoulder, two times a week over six weeks is medically necessary.

**Percocet 10/325mg number ninety (#90):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Page(s): 79-81.

**Decision rationale:** CA MTUS states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time, such as in a postoperative setting. Given the certification of the associated surgical procedure, the request for Percocet #90 in the post-op period is appropriate. Therefore, the request for Percocet 10/325 mg number ninety (#90) is medically necessary.

**Oxycontin 10mg number sixty (#60):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Page(s): 79-81.

**Decision rationale:** CA MTUS states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time, such as in a postoperative setting. Given the certification of the associated surgical procedure, the request for Oxycontin #60 in the post-op period is appropriate. Therefore, the request for Oxycontin 10mg number sixty (#60) is medically necessary.

**Colace 250mg number thirty (#30):** Overturned

**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 Page(s): 77.

**Decision rationale:** CA MTUS states that with opioid therapy, prophylactic treatment of constipation should be initiated. Given that the associated surgery and post-op opiate medications were certified, post-op Colace is appropriate. Therefore, the request for Colace 250 mg number thirty (#30) is medically necessary.