

Case Number:	CM15-0110464		
Date Assigned:	06/17/2015	Date of Injury:	05/17/2012
Decision Date:	08/18/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/08/2015

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:

This injured worker is a 58-year-old female who sustained an industrial injury on 5/17/12. Injury occurred when she slipped and fell to the floor while trying to disassemble a box. She underwent left shoulder rotator cuff repair with anterior acromioplasty, resection of the coracoacromial ligament, bursectomy, and glenohumeral arthroscopy with synovectomy and debridement on 10/31/12. The 11/28/14 left shoulder MRI impression documented surgical changes compatible with supraspinatus tendon repair. The surgical construct appeared largely intact without frank evidence for a large defect or retraction. Evaluation of the labral structures was very limited due to motion. The 1/28/15 left shoulder MR arthrogram documented no significant acromioclavicular (AC) joint arthropathy. There was communication of contrast between the rotator cuff and the subacromial/subdeltoid space, suspicious for full thickness tear of the rotator cuff, and extensive tendinopathy of the subscapularis. There were no focal chondral defects or labral injury. The 3/10/15 treating physician report cited continued left shoulder pain and weakness, worse with overhead activities. Symptoms had not responded to conservative treatment including physical therapy, chiropractic care, acupuncture, anti-inflammatory medication, and cortisone injection. Left shoulder exam documented tenderness to palpation over the rotator cuff, and painful range of motion. Left shoulder range of motion included flexion 160, extension 40, abduction 150, adduction 40, and internal/external rotation 70 degrees. Imaging demonstrated a full thickness tear with very limited evaluation of the labral structures due to motion. Authorization was requested for revision of left shoulder diagnostic arthroscopy, possible synovectomy, labral repair, subacromial decompression, distal clavicle excision, and

rotator cuff repair, and postoperative physical therapy 3X4, cold therapy unit, and sling. The 5/28/14 utilization review non-certified the left shoulder diagnostic arthroscopy with possible synovectomy, labral repair, subacromial decompression, distal clavicle excision, and rotator cuff repair and associated requests as there were no clinical signs of impingement documented and no evidence that conservative treatment has been exhausted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder diagnostic arthroscopy, possible synovectomy, labral repair, subacromial decompression, distal clavicle excision and rotator cuff repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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 Impingement syndrome; Surgery for rotator cuff repair; Partial claviclectomy, Surgery for SLAP lesions.

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 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, usually full passive range of motion, and positive imaging evidence of rotator cuff deficit. Guideline criteria for partial claviclectomy include subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint pathology. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have been met. This injured worker presents with persistent left shoulder pain and weakness, worse with overhead elevation. Signs/symptoms and clinical findings are consistent with imaging evidence of full thickness rotator cuff tear. Definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Evidence of 3 to 6 months of a reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is medically necessary at this time.

Post operative physical therapy 3 times a week for 4 weeks: Overturned

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 California MTUS Post-Surgical Treatment Guidelines for impingement syndrome 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. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.

Associated surgical services: Cold therapy unit: 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.

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. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request for one cold therapy unit is not medically necessary.

Associated surgical services: 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, immobilization.

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

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