

Case Number:	CM15-0111864		
Date Assigned:	06/18/2015	Date of Injury:	03/31/2011
Decision Date:	08/26/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	06/10/2015

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 51-year-old female who sustained an industrial injury on 3/31/11. Injury was reported while she working as an LVN and pushing a medication cart with improperly working wheels. She was diagnosed with a massive right rotator cuff tear that was retracted and underwent a right shoulder rotator cuff repair on 10/21/13. A bilateral shoulder diagnostic ultrasound was performed on 11/4/14. The left shoulder ultrasound exam documented a large full thickness rotator cuff tear involving the distal supraspinatus tendon. The tendon was retracted medially, however there was no significant atrophy. The infraspinatus, teres minor, and subscapularis tendons appeared intact. There was hypertrophic degenerative change involving the left AC joint. There was fraying and degenerative change of the anterior-superior glenoid labrum. The 4/22/15 treating physician report cited constant slight to moderate pain in the left shoulder with associated clicking and catching. Pain was aggravated by lifting, pushing, pulling, or use of the arm at or above shoulder height. Left shoulder exam documented moderate tenderness over the subacromial bursa and authorization (AC) joint, and slight collapsing weakness with resisted abduction. Circumduction caused moderate pain and crepitation, and there was positive Neer's impingement sign. Right shoulder range of motion testing documented forward flexion 120, abduction 120, external rotation 60, and internal rotation 40 degrees with pain. The diagnosis included full thickness rotator cuff tear left shoulder with impingement and AC joint arthritis. The injured worker was quite symptomatic despite conservative treatment with oral and topical anti-inflammatory medications, severe corticosteroid injection injections, physical therapy, acupuncture, activity modification, and stretching and strengthening exercises.

The AME noted a full thickness left rotator cuff tear and recommended surgical repair. Authorization was requested for left shoulder arthroscopic rotator cuff repair; pre-operative medical clearance, and post-operative physical therapy for 12 sessions. The 5/18/15 utilization review non-certified the left shoulder arthroscopic rotator cuff repair and associated surgical requests as there was no documentation of an imaging report.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder left shoulder arthroscopic rotator cuff repair: 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 Chapter.

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: Rotator cuff repair.

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 have been met. This injured worker presents with persistent and function-limiting right shoulder pain. Clinical exam findings are consistent with diagnostic ultrasound evidence of a full thickness retracted rotator cuff tear. Detailed evidence of 3 to 6 months of recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Pre-op medical clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation, Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient age, long-term use of non-steroidal anti-inflammatory drugs, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Post-op physiotherapy two times a week for six weeks quantity: 12: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.