

Case Number:	CM15-0170700		
Date Assigned:	09/16/2015	Date of Injury:	01/22/2007
Decision Date:	12/10/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	08/31/2015

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 49-year-old male who sustained an industrial injury on 1/22/07. Injury occurred while he was working as an airline equipment service technician and off-loading an 8x12 container with onset of left shoulder pull and pain. Past surgical history was positive for anterior cervical discectomy and fusion C4/5 and C5/6 on 2/29/08, artificial disc replacements at C3/4 and C6/7 on 2/20/09, spinal cord stimulator implantation, right ulnar nerve transposition with medial epicondylar debridement, and three left shoulder surgeries including arthroscopic labral and subacromial debridements with rotator cuff repair. The 7/14/15 CT arthrogram impression documented a full thickness tear of the supraspinatus tendon. There was a widened acromioclavicular (AC) joint compatible with intermediate grade separation without depression of the acromion or widened acromioclavicular interval. The 7/27/15 treating physician report indicated that the injured worker had undergone a CT arthrogram of the left shoulder with radiologist findings of a supraspinatus tear. He could not have an MRI because of his spinal cord stimulator. The injured worker wanted to address the left shoulder and nothing was going to be done immediately about his cervical spine. The report from the cervical spine surgeon had not been received. Physical exam documented full active assist range of motion with flexion 160 degrees. He had positive Neer and Hawkin's signs. There was no AC joint tenderness or cross body adduction pain localized to the AC area. There was some mild biceps swelling and tenderness. There was supraspinatus weakness but no external rotation or belly press weakness. Apprehension test was negative. The CT arthrogram was reviewed. The treating physician stated that he was not entirely convinced that the supraspinatus tear was a full thickness tear as there

were no clear dye tracks from the joint to the bursa, but there was dye in the bursa. There was no significant degenerative change in the glenohumeral joint, no os acromion, and the acromion was fairly flat. There was no obvious subscapularis or labral tear. Conservative treatment had included 6 subacromial injections with benefit but this was probably far too many. He was taking anti-inflammatory medications. He had been through multiple courses of physical therapy and was well-versed in home exercise. The treating physician felt that a revision rotator cuff repair was indicated and doubted that any bony work would be required. The last left shoulder surgery was noted in 2006. Authorization was requested for left shoulder examination under anesthesia with arthroscopic examination, rotator cuff repair or debridement, and treatment of other pathologies as indicated with associated surgical requests for pre-op medical clearance and purchase of a cold therapy unit. The 8/3/15 utilization review non-certified the left shoulder surgery and associated surgical requests as there was no recent x-ray evidence of a rotator cuff deficit, no subjective clinical findings of inability to elevate the arm or tenderness over the greater tuberosity, and no indication that cervical pathology had been ruled-out.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder examination under anesthesia with arthroscopic examination, Rotator cuff repair or debridement and treatment of other pathologies as indicated: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for rotator cuff repair.

Decision rationale: The California MTUS guidelines provide a general recommendation for rotator cuff surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. 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 left shoulder pain. Clinical exam findings are consistent with imaging evidence of a full thickness rotator cuff tear. Diagnostic injection tests have been positive. Detailed evidence of up to 6 months a 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 Official Disability Guidelines (ODG)-preoperative testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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 males 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, chronic opioid therapy, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Associated Service: Cold therapy unit for the left shoulder, purchase: 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).

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. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. 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 is not medically necessary.