

Case Number:	CM15-0070176		
Date Assigned:	04/17/2015	Date of Injury:	04/08/2011
Decision Date:	07/07/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/13/2015

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:

The injured worker is a 64-year-old female who sustained an industrial injury on 4/08/11. Injury occurred when she tripped in a parking lot and fell on her outstretched right arm. The 4/14/14 right shoulder MRI impression documented moderate tendinosis of the supraspinatus tendon with small intrasubstance tear anteriorly at the insertion of the supraspinatus tendon. There was a high-grade tear of the distal rotator cuff tendon near the junction of the supraspinatus and infraspinatus tendons, with a possible full thickness component. Findings were also suggestive of a tear of the anterior superior labrum. There was a small amount of fluid in the subacromial / subdeltoid bursa, which could be related to bursitis, and mild acromioclavicular (AC) joint osteoarthritis. The 3/19/15 treating physician report indicated that the injured worker was last seen on 5/29/14. Surgery had been discussed at that time, but she had been unable to take off from work due to staffing issues. She presented with worsening symptoms. She had increased pain, especially at night. She had increased pain and weakness with overhead reaching. Physical exam documented slightly decreased elevation, significant weakness and pain on resisted supraspinatus testing, and positive 90-90, Hawkin's, and Whipple tests. Imaging showed a high-grade partial thickness tear with possible full thickness component. Authorization was requested for right shoulder arthroscopy and rotator cuff repair, pre-operative medical clearance, post-op sling, cold therapy unit for 7 days, and physical therapy x 12 visits. The 3/30/15 utilization review non-certified the right shoulder surgery and associated surgical requests as there was no evidence of a recent course of conservative treatment. The 4/6/15 treating physician report indicated that the injured worker had been initially treated with ibuprofen with minimal

improvement and 8 sessions of physical therapy with 20% improvement. She underwent a corticosteroid injection on 11/22/11, which made her symptoms better. She presented on 4/1/14 with increased shoulder pain. Current medications included Aleve and Tylenol. She underwent a second corticosteroid injection on 4/24/14 with some relief, but pain and weakness continued. As of 3/19/15, she had significant supraspinatus weakness and pain, and positive 90-90, Hawkin's, and Whipple tests. She had night pain, pain with reaching overhead, and slight shoulder weakness especially with overhead reaching. She had clearly tried and failed a conservative course of treatment including oral anti-inflammatories, physical therapy, and 2-subacromial corticosteroid injection with on-going symptoms. There was evidence on the MRI that her rotator cuff tear had slightly increased. Surgery was again requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder surgery: 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), Indications for Surgery.

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 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 of partial thickness tears generally require 3 to 6 months of conservative treatment, plus painful arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, rotator cuff or anterior acromial tenderness, and positive impingement sign with a positive diagnostic injection test. Criteria include imaging evidence of a rotator cuff deficit. Guideline criteria have been met. This injured worker presents with worsening right shoulder pain and weakness, especially at night and with overhead reaching. Clinical exam findings are consistent with imaging evidence of rotator cuff tear. There was evidence of a positive diagnostic injection test. Detailed evidence of at least 6 months of reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Surgery was reportedly delayed due to work staffing issues. Therefore, this request is medically necessary at this time.

Associated surgical services: Pre-op 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 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.

Associated surgical service: Post-op sling: Overturned

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): 205, 213.

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative immobilizer is generally indicated. Therefore, this request is medically necessary.

Associated surgical services: Cold therapy x 7 days: 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 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 requested 7-day use of a cold therapy unit is consistent with guidelines. Therefore, this request is medically necessary.

Associated surgical services: Physical therapy x 12: 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 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.