

Case Number:	CM15-0078930		
Date Assigned:	04/30/2015	Date of Injury:	05/16/2005
Decision Date:	06/29/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/24/2015

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 43-year-old female who sustained an industrial injury on 5/16/05. The mechanism of injury was not documented. Conservative treatment included medications, physical therapy, and activity modification. The 4/1/15 left shoulder MR arthrogram impression documented supraspinatus tendinosis with extension of the contrast into the substance of the supraspinatus tendon compatible with partial thickness articular surface and interstitial tearing. There was no definite labral tear. The 4/10/15 treating physician report cited increasing discomfort in the left shoulder with any sort of picking up, and feeling that it shifted out of position. Physical exam documented active flexion 150, abduction 140, and external rotation 50 degrees with some compensatory posturing. There was positive impingement and impingement reinforcement. MRI findings were consistent with partial undersurface attritional tearing. There was subtle anterior instability of the left shoulder with underlying ligament laxity. The injured worker remained off work due to increased symptomatology and pain with activities of daily living. Surgery was recommended to include arthroscopic subacromial decompression, rotator cuff repair, and potential labral repair/capsulorrhaphy for the left shoulder. Authorization was requested for pre-op medical clearance, pre-op labs to include CMP, PT, PTT, UA, CBC, EKG, chest x-ray, durable medical equipment to include Ultrasling, arm sling, cold therapy unit, DVT machine, and post-operative aquatic therapy for the left shoulder 2x4. The 4/17/15 utilization review non-certified the left shoulder arthroscopic subacromial decompression with rotator cuff repair potential labral repair/capsulorrhaphy, and associated surgical requests, as there was no detailed documentation of recent conservative treatment response and no imaging evidence of

impingement or labral pathology. The 4/22/15 progress report cited continued anterolateral left shoulder pain, improved somewhat with rest and activity modification. Physical exam documented positive impingement and impingement reinforcement. Active range of motion testing documented flexion 165, abduction 150, and external rotation 65 degrees without gross compensatory posturing. The treating physician report documented subtle anterior instability of the left shoulder with underlying ligamentous laxity. There was progression in the undersurface attrition of the rotator cuff noted on recent MR arthrogram consistent with partial articular supraspinatus tendon avulsion lesions. She had a longstanding history of instability and shows gross capsular laxity and possible labral attrition that would require addressing at the time of arthroscopic surgery. The injured worker had von Willebrand's and will be a candidate for medications and monitoring for any surgical procedure to prevent untoward complications with bleeding. Appeal of the surgical denials was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic subacromial decompression, rotator cuff repair as indicated with potential labral repair/capsulorraphy for the left shoulder: Overturned

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

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 SLAP lesions; Surgery for shoulder dislocation.

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 state that definitive diagnosis of labral lesions is diagnostic arthroscopy and support surgical treatment when conservative treatment has failed. Guidelines typically support shoulder capsular surgery with when instability occurs frequently or during daily activity. Guideline criteria have been met. This injured worker presents with persistent shoulder pain and instability with activities of daily living. Functional difficulties have precluded return to work. Clinical exam findings are consistent with capsular laxity and possible labral attrition, and imaging evidence of progressive rotator cuff pathology. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Pre-operative medical clearance, per-operative labs to include (CPT, PT, PTT, UA, CBC):
Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back., Preoperative lab testing.

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; Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. Guideline criteria have been met based on patient's age, documented co-morbidities, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

DME; Ultrasling, arm sling, cold therapy unit with pads, DVT machine rental with cuffs for purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213. Decision based on Non-MTUS Citation Shoulder: Postoperative abduction pillow sling; Continuous flow cryotherapy; Venous thrombosis.

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines state that post-operative abduction pillow slings, are recommended as an option following open repair of large and massive rotator cuff tears. Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The Official Disability Guidelines (ODG) recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures, such as consideration for anticoagulation therapy. The administration of DVT prophylaxis is not generally recommended in upper extremity procedures. Guideline criteria have not been met for an Ultrasling as there was no evidence that this injured worker had a large rotator cuff tear or required open surgical repair. The use of a standard arm sling would be reasonable and is consistent with guidelines. 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. DVT (deep vein thrombosis) prophylaxis would be generally appropriate for this injured worker based on co-morbidities but there is no compelling

reason to support purchase over short term rental. Given the above discussion, the total request cannot be considered medically necessary.

Aquatic Therapy 8 sessions left shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 24, Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for rotator cuff repair/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. Guidelines support the use of aquatic therapy as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Post-operative physical therapy would be appropriate for this injured worker following the requested shoulder surgery. However, there is no compelling rationale presented to support the medical necessity of aquatic therapy over land-based physical therapy for post-operative shoulder rehabilitation. Therefore, this request is not medically necessary.