

<b>Case Number:</b>	CM15-0090599		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	03/06/2015
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	05/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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 57-year-old male who sustained an industrial injury on 3/6/15. Injury occurred relative to moving a coffee machine. Past medical history was positive for hypertension. Past surgical history was positive for left shoulder arthroscopy with glenohumeral debridement, subacromial decompression, and acromioplasty in 2013. Initial conservative treatment included physical therapy, anti-inflammatory medication, pain medication, activity modification, and icing. The 3/21/15 left shoulder MRI impression documented rotator cuff tendinosis with focal partial thickness tear of the infraspinatus footprint fibers. There was significant thinning and attenuation of the supraspinatus fibers and partial thickness tear of the subscapularis. There was chronic biceps tendinosis, subluxed over the lesser tuberosity. There were degenerative changes of the labrum with partial thickness tear at the posterosuperior quadrant. There were severe tears of the teres major and moderate to severe tears of the teres minor, and moderate deltoid muscle atrophy. Findings documented moderate degenerative changes over the AC joint with subcortical cysts, joint space narrowing and marginal spurring. The 3/25/15 physical therapy note cited worsening left shoulder pain with instability, popping and clicking. The injured worker was visibly uncomfortable and held the arm next to his body and was hesitant to move it or have it touched. Transfer of care to the orthopedic surgeon was noted. The 4/1/15 orthopedic consult report cited a significant increase in pain and weakness of the left shoulder. Left shoulder exam documented no obvious bruising or swelling, or muscle atrophy. There were positive signs of impingement. Left shoulder range of motion testing demonstrated forward flexion to 120 degrees and abduction to 110 degrees. There was a

significant increase in pain with the shoulder placed in abduction and external rotation. Jobe test was mildly positive. There was tenderness over the bicipital groove with direct palpation and positive Speed and Yergason's tests. MRI findings were reviewed. The diagnosis was left shoulder biceps tendinitis with subluxation, rotator cuff partial thickness tearing, labral tear, and AC joint arthritis. The injured worker had tried some physical therapy and it was not helpful and was using anti-inflammatory medications. He had on-going pain and was not making any improvements. Authorization was requested for left shoulder arthroscopic distal clavicle resection, biceps tenodesis and labral repair, subacromial decompression and rotator cuff repair, and associated surgical requests. The 5/1/15 utilization review non-certified the left shoulder arthroscopic distal clavicle resection, biceps tenodesis and labral repair, subacromial decompression and rotator cuff repair, and associated surgical requests as there was no evidence that the injured worker had complete a full course of non-operative therapy per guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Distal clavicle Resection Arthroscopic, Bicep Tenodesis and Labral Repair Left Shoulder, Arthroscopy w/Subacromial Decompression, Rotator Cuff Repair: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Labrum tear surgery.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 179-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for impingement syndrome; Surgery for rotator cuff repair; 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 provide indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. SLAP surgery is recommended for patients under age 50, otherwise biceps tenodesis is recommended. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have been essentially met. This injured worker presents with significant left shoulder pain with instability, popping and clicking. There is severe functional loss. He is status

post prior arthroscopy surgery. Clinical exam findings are consistent with imaging evidence of significant tearing involving all components of the rotator cuff and the labrum. There is evidence of a reasonable conservative treatment trial and failure. There is progressive worsening of signs/symptoms documented. Therefore, this request is medically necessary.

**Pre-op EKG: 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); Low Back - Online version, preoperative electrocardiogram.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Guideline criteria have been met. Middle-aged females have known occult increased risk factors for cardiovascular disease that support the medical necessity of pre-procedure EKG. Therefore, this request is medically necessary.

**Pre-op Physical Therapy 2 x 4: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 17 and 27.

**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 request is for post-op physical therapy and is consistent with initial treatment guidelines. Therefore, this request is medically necessary.

**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); Continuous-flow cryotherapy.

**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.

**Ultra Sling Shoulder:** 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- Online Version, postoperative abduction pillow sling.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

**Decision rationale:** The California MTUS are silent regarding post-op abduction pillow slings. The Official Disability Guidelines state that these slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have been met for the use of this post-op sling. There is imaging evidence of tears involving all components of the rotator cuff and the labrum. The use of this sling is reasonable to support the surgical correction and for pain management. Therefore, this request is medically necessary.