

Case Number:	CM15-0098388		
Date Assigned:	05/29/2015	Date of Injury:	04/13/2012
Decision Date:	07/03/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/21/2015

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 52-year-old male who sustained an industrial injury on 4/13/12. Injury was reported due to repetitive lifting of garbage cans for years as a waste management worker. Past medical history was positive for hypertension. The 4/10/15 MRI impression documented moderate to severe rotator cuff tendinosis most severely involving the supraspinatus tendon. There was a high-grade partial articular surface disruption of the subscapularis tendon. There was a partial interstitial disruption and bursal surface fraying of the supraspinatus tendon with no evidence of a transmural tear. There was long head biceps tendon tendinosis with medial subluxation of the tendon at the rotator interval and partial disruption of the intra-articular portion of the tendon. There was degenerative fraying of the supraspinatus labrum and biceps labral anchor. There was a type I acromion with moderate lateral downward inclination and moderate large amount of fluid in the subacromial subdeltoid bursa compatible with bursitis. The 4/13/15 treating physician report cited constant severe anterior left shoulder pain. He could not move his arm to the side or reach for anything. He was having difficulty sleeping. Physical exam documented tenderness over the anterolateral acromion, minimal tenderness over the biceps tendon, and global rotator cuff weakness. Passive right shoulder range of motion was to 75 degrees. He had active flexion and abduction of about 45 degrees. MRI was reviewed and showed a high grade, probable complete, supraspinatus tear. The diagnosis was supraspinatus and partial subscapularis tear. He had clinical findings consistent with rotator cuff tear, and was unable to function. Authorization was requested for left shoulder arthroscopy rotator cuff repair with decompression, polar care unit, Ultrasling, and post-op physical therapy (unspecified)

amount). The 5/11/15 utilization review non-certified the left shoulder arthroscopic rotator cuff repair with decompression and associated surgical requests as the injured worker had only limited documentation of conservative treatment and no documentation of a subacromial corticosteroid injection and results. The 5/12/15 orthopedic appeal letter requested reconsideration of the left shoulder rotator cuff repair. He reported the injured worker had ongoing severe pain and simply had no function. The physician documented he could not move the injured worker's arm without him crying and screaming in pain, and he did not think therapy would help. The injured worker had previously refused a corticosteroid injection, but a subacromial corticosteroid injection was performed today. Physical exam documented flexion and abduction of 45 degrees, and external rotation 10 degrees. He had passive movement to 90 degrees. There was 4/5 supraspinatus and external rotation weakness. Surgery was again requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy Rotator Cuff Repair with Decompression: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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 essentially met. This injured worker presents with severe right shoulder pain and marked loss of function. Clinical exam findings are consistent with imaging evidence of rotator cuff tear. Evidence of 3-6 months of a reasonable non-operative treatment protocol trial, including activity modification and medications, and failure has been submitted. Therefore, this request is medically necessary.

Post-Op Physical Therapy Unspecified Amount: Upheld

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 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 post-surgical physical medicine period. Post-operative physical therapy for this injured worker would be reasonable within the MTUS recommendations. However, this request is for an unknown amount of treatment which is not consistent with guidelines. Therefore, this request is not medically necessary.

Associated Surgical Service: Polar Care Unit Unspecified Days: Upheld

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. 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.

Associated Surgical Service: Ultrasling: Upheld

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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

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. Guideline criteria have not been met. An arthroscopic repair of a partial thickness rotator cuff tear is planned. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request is not medically necessary.

