Case Number:	CM17-0007142		
Date Assigned:	01/12/2017	**Date of Injury:**	11/06/2016
Decision Date:	02/13/2017	**UR Denial Date:**	12/23/2016
Priority:	Standard	**Application Received:**	01/03/2017

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: California, Texas
Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 case involves a now 58-year-old female with a history of an occupational claim from 11/06/2016. The mechanism of injury is detailed as opening a locked medication room door. The current diagnoses are documented as right shoulder full thickness rotator cuff tear, acromioclavicular joint arthrosis, and degenerative labral tears. Prior treatments were not noted. The diagnostic studies included an MRI of the right shoulder on 11/18/2016, which revealed a full thickness tear nearly the entire AP with the supraspinatus tendon, proximal to the footprint, with a 9 mm stump remaining attached to the greater tuberosity with a 5 mm tear gap. The torn ends were in close proximity to 1 another. There was no supraspinatus muscle atrophy. There was high grade cartilage loss in the acromioclavicular joint with subchondral cystic changes and mild inferior spurring exerting mild mass effect upon the underlying myotendinous junction of the supraspinatus. There was moderately severe thickening and tendinosis of the biceps tendon just proximal to the bicipital groove with an hourglass appearance. There was minimal medial deviation into the attritional fibers of the intact subscapularis tendon. There was small to moderate glenohumeral joint effusion. The documentation of 12/06/2016 indicated the patient had pain in the right shoulder. The patient worked at a hospital and was having difficulty performing her physical demanding job due to right shoulder pain and weakness. The patient was currently taking nonsteroidal anti-inflammatory drugs and oxycodone for chronic low back pain. The patient had tenderness to palpation in the acromioclavicular joint. Passive range of motion was limited to flexion of 80 degrees, abduction 70 degrees, and external rotation of 45 degrees due to pain. Active range of motion was limited to flexion of 60 degrees, abduction 45 degrees,

and internal rotation to the iliac crest due to pain and reported weakness. The strength was 4/5 in abduction and external rotation with significant pain. Internal rotation strength was 5/5 with pain. The patient had a positive drop arm, lift off, and cross over impingement sign. The treatment plan included an arthroscopic surgery to repair the rotator cuff, decompression and a Mumford procedure for the acromioclavicular joint, which was creating a level of impingement and debridement of the labrum. The patient's range of motion was limited. The physician indicated that there was a concern for adhesive capsulitis developing. Surgical intervention was requested. The Request for Authorization was dated 12/15/2016. The requested treatment was denied on 12/23/2016. The rationale for denial indicated there was insufficient evidence to support the medical necessity for the requested procedure. Additionally, there were conflicting statements between initial reports and progress reports as a single event or gradual onset over the course of several months. 1 provider stated this was not a Workers' Compensation injury. Furthermore, it was indicated the patient reported right shoulder pain that required medical intervention; however, she was able to participate in bowling 3 times per week and acknowledged that bowling did not aggravate her injury but pulling and lifting did. The patient did not have diminished function. As the surgical intervention was not medically necessary, associated requests were not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with subacromial decompression, acromioplasty, Mumford, rotator cuff repair and shoulder debridement: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute and Chronic), Rotator cuff repair, Acromioplasty, Mumford procedure.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: The ACOEM Guidelines indicate that surgical considerations are appropriate for patients who had activity limitations for more than four months and for a patient who has had a failure to increase range of motion and strength of musculature around the shoulder even after exercise programs and when there is clear clinical and imaging evidence of a lesion that has been shown to benefit in the long and short term from surgical repair. Additionally regarding a rotator cuff tear, a rotator cuff repair is indicated for significant tears that impair activities by causing weakness and arm elevation or rotation, particularly acutely in younger workers. For partial thickness rotator cuff tears and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months, the preferred procedure is arthroscopic decompression which involves debridement of the inflamed tissue, burring of the anterior acromion, lysis and sometimes removal of the coracoacromial ligament and possibly removal of the outer clavicle. Surgery is not indicated for patients with mild symptoms or those whose activities are not limited. Regarding impingement syndrome, conservative care may include cortisone injections and therapy, which can be carried

out for 3 to 6 months before considering surgery. The documentation indicated the patient reported injury on 11/06/2016. The prior review indicated that the patient was bowling. However, per the documentation, the patient had stopped bowling when she reported injury. The patient had difficulty with overhead activities. The patient had objective findings on physical examination including a positive drop arm, lift off, and cross over impingement test. The MRI indicated the patient had a full thickness tear. This type of a tear would not respond to conservative treatment. The patient had a high grade cartilage loss in the acromioclavicular joint with subchondral cystic changes and mild inferior spurring exerting mild mass effect upon the underlying myotendinous junction of the supraspinatus. While the patient had not undergone conservative care in the form of physical medicine treatment, due to the severity of the tearing, conservative care would not be appropriate. As such, the requested surgical intervention is medically necessary.

Assistant PA: Overturned

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule Search.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Surgical assistant.

Decision rationale: The Official Disability Guidelines indicate a surgical assistant is available for a complex surgery. The patient has been approved to undergo a complex surgical procedure. As such, the requested "Assistant PA" is medically necessary.

Pre-operative medical clearance: Overturned

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Medicare Physicians Fee Schedule (MPFS); Chapter 12-Surgeons and Global Surgery; 40.1-Definition of a Global Surgical Package.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

Decision rationale: According to the ACOEM Guidelines, the request for a referral is supported when it is necessary to plan a course of care that may benefit from additional expertise. The documentation supported surgical intervention. The patient is over 50 years of age. Due to this fact, a preoperative medical clearance would be appropriate. As such, the requested "Pre-operative medical clearance" is medically necessary.

Pre-operative EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative electrocardiogram (ECG).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines and ACOEM guidelines do not address preoperative EKG. The Official Disability Guidelines indicate a preoperative electrocardiogram is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. The study is not recommended for arthroscopic surgery. The documentation indicated the patient is over the age of 50. However, there was no indication the patient had additional risk factors. The patient was not to be undergoing a high risk or intermittent risk surgery. As such, the requested "Pre-operative EKG" is not medically necessary.

Pre-operative CBC: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative lab testing.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines and ACOEM guidelines do not address the request. The Official Disability Guidelines indicate that a complete blood count is appropriate for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. The patient is a 58-year-old female and a complete blood count would be appropriate for a patient of advanced age. As such, the requested laboratory study is medically necessary.

Pre-operative BMP: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative lab testing.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines and ACOEM guidelines do not address the request. The Official Disability Guidelines indicate that electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. The patient

is a 58-year-old female. A basic metabolic panel would be appropriate for a patient of advanced age. As such, the requested laboratory study is medically necessary.

Pre-operative PT/PTT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative lab testing.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines and ACOEM guidelines do not address the request. The Official Disability Guidelines indicate that coagulation studies are reserved for patients with a history of bleeding or a medical condition that predispose them to bleeding or those taking anticoagulants. There was a lack of documentation indicating the patient had a history of bleeding or medical condition the predisposed her to bleeding or that she was taking anticoagulants. As such, the requested "Pre-operative PT/PTT" is not medically necessary.

Associated surgical service: Cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute and Chronic), Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous-flow cryotherapy.

Decision rationale: The California MTUS and ACOEM Guidelines do not address the cold therapy unit. The Official Disability Guidelines indicate a cold therapy unit is appropriate for patients for up to 7 days postoperatively. The request as submitted indicated the request was for a cold therapy unit. The duration of use was not noted. Purchase is not supported over rental. As such, the requested "Associated surgical service: Cold therapy unit" is not medically necessary.

Associated surgical service: Arc sling: Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute and Chronic), Postoperative abduction pillow sling.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Postoperative abduction pillow sling.

Decision rationale: The California MTUS and ACOEM Guidelines do not address an arc sling. The Official Disability Guidelines indicate that a postoperative abduction pillow sling is recommended following the open repair of a large and massive rotator cuff tear, but not for patients undergoing arthroscopy. While the patient had a large rotator cuff tear, the treatment is not recommended for arthroscopic repair. The patient was approved to undergo arthroscopic repair. As such, the requested "Associated surgical service: Arc sling" is not medically necessary.