

<b>Case Number:</b>	CM13-0010759		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	05/16/2012
<b>Decision Date:</b>	03/05/2014	<b>UR Denial Date:</b>	08/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

In a Utilization Review Report of August 5, 2013, the claims administrator denied a request for shoulder surgery and also denied a request for postoperative DME and postoperative physical therapy. The applicant later appealed, on August 12, 2013. The utilization reviewer states that the applicant's shoulder MRI demonstrated acromioclavicular joint disease, but no evidence of rotator cuff tear. The applicant, however, did not attach any rational or clinical progress notes to the appeal. The applicant's treating physician did write a letter dated August 15, 2013, stating that the applicant carries a diagnosis of shoulder impingement syndrome. The applicant has pain and tenderness over the shoulder with positive signs of internal impingement. The attending provider states that the applicant has failed conservative treatment. The attending provider goes on to put forth a request for shoulder arthroscopy, a shoulder sling, and a continuous cooling-heating unit postoperatively. Postoperative physical therapy is also sought.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient right shoulder acromioclavicular resection with subacromial 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**Decision rationale:** As noted in the MTUS-Adopted ACOEM Guidelines in chapter 9, the surgery for impingement syndrome is usually arthroscopic decompression. Surgery is not, however, per the ACOEM Guidelines, indicates for those individuals with mild symptoms or who have no activity limitations. Conservative care usually results in resolution of impingement syndrome and should be carried on for three to six months before surgery is considered. In this case, however, the applicant was 15 months removed from the date of injury at the time surgery was requested. Both the attending provider and the utilization reviewer have acknowledged that the applicant did carry a diagnosis of active shoulder impingement syndrome, which has proven recalcitrant to conservative measures. Pursuing a shoulder arthroscopic decompression surgery is indicated. The request for outpatient right shoulder acromioclavicular resection with subacromial decompression is medically necessary and appropriate.

**Post operative DME shoulder sling:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM.

**Decision rationale:** The Third Edition ACOEM Guidelines note that postoperative usage of a shoulder sling can be used to advance the actively level postoperatively. Based on the medical records provided for review the patient meets the guidelines criteria for the purchase of a shoulder sling. The request for the purchase of a Post-operative DME shoulder sling is medically necessary and appropriate.

**Purchase of a motorized hot/cold unit:** 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) ), Continuous Flow Cryotherapy Topic

**Decision rationale:** The MTUS does not address the topic of motorized hot and cold units. As noted in the Official Disability Guidelines (ODG), Continuous Flow Cryotherapy Topic, continuous cooling devices can be employed for up to seven days postoperatively. Continuous cooling devices are not recommended beyond the seven-day mark of the date of surgery. In this case the request is for the purchase of a motorized hot and cold unit which is not recommended by the ODG. The request for a motorized hot and cold unit is not medically necessary and appropriate.

**Post operative physical therapy two times a week for four weeks:** 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.

**Decision rationale:** As noted in the California MTUS Guidelines, an initial course of postoperative therapy represents one half of the course of overall therapy recommended for a specific surgery. In this case, up to 24 sessions are supported following shoulder arthroscopy. Thus, an initial course of postoperative therapy could have represented up to 12 sessions of treatment. Therefore, the eight session course of treatment being proposed here is indicated and does conform to the MTUS Guidelines. The request for post operative physical therapy two times a week for four weeks is medically necessary and appropriate.