

<b>Case Number:</b>	CM13-0014372		
<b>Date Assigned:</b>	10/03/2013	<b>Date of Injury:</b>	10/05/2006
<b>Decision Date:</b>	01/30/2014	<b>UR Denial Date:</b>	07/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2013

### 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:

The patient a 43-year-old female who has filed a claim for shoulder pain reportedly associated with an industrial injury that took place on October 5, 2006. Thus far, the patient has been treated with the following. Analgesic medications, prior carpal tunnel release surgery, subsequent diagnosis with carpal tunnel syndrome, along with extensive periods of time off of work. In a March 5, 2013 progress notes that the patients physician created state that she has MRI evidence of split biceps tendon tear, partial supraspinatus undersurface tear, and a labral tear. The patient has tried and failed physical therapy, time, medications, and other conservative measures. A later note of July 11, 2013 state that the patient has failed non-operative treatments for the left shoulder, has positive provocative testing, and has extreme pain with flexion and abduction, limited to 60 degrees. The patient remains off of work and is on total temporary disability. In a utilization review report of July 16, 2013, the claims administrator apparently denied MRI. No guidelines were clearly cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy with bioceps tenodesis, labral repair, subacromial decompression, distal clavicle excision, rotator cuff repair, post-operative physical therapy 3 times a week for 4 weeks, shoulder brace with abduction pillow, purchase of cold unit therapy is medically necessary and approp: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation ODG Shoulder Chapter, continuous-flow cryotherapy

**Decision rationale:** The independent medical review process does not afford reviewing physicians with the opportunity to issue conditional, qualified, or partial certifications. While some items such as the proposed cold therapy unit would have been better modified to rentals, modifications are not possible here. The most critical item being requested here is the shoulder arthroscopy. As noted in the MTUS-adopted ACOEM guidelines in chapter 9, surgery for impingement syndrome is usually an arthroscopic decompression. Rotator cuff repair is indicated for those individuals with significant tears that impair activities which cause weakness of arm elevation or rotation, particularly in younger worker. In this case, the applicant seemingly has a partial thickness rotator cuff tear versus impingement syndrome versus labral tear. She is a younger worker (age 43). She has exhausted a number of conservative remedies including, time, medications, physical therapy, steroid injections, etc. Given the failure of conservative measures here, surgical decompression, labral repair, rotator cuff repair, etc. are all indicated. The request for physical therapy postoperatively is approved on the grounds that MTUS 9792.24.3 does endorse an initial course of 12 sessions of physical therapy following rotator cuff repair surgery. The third edition ACOEM guidelines support usage of a sling to advance the activity level postoperatively. Therefore, this portion of the request is likewise certified. Since the MTUS does not address the topic, the third edition ACOEM guidelines were selected. Finally, the cold therapy unit portion of the request is also certified, as partial certification or modification to a rental would not be possible here through the IMR process. Again, the MTUS does not address this topic. The ODG shoulder chapter continuous-flow cryotherapy does endorse continuous cooling devices for up to one week postoperatively. This request is likewise certified along with the remainder of the requests, which were collectively submitted as one request as opposed to separately.