MAXIMUS Federal Services

| Case Number: | CM13-0051505 | | |
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| Date Assigned: | 12/27/2013 | Date of Injury: | 08/24/2012 |
| Decision Date: | 03/07/2014 | UR Denial Date: | 11/11/2013 |
| Priority: | Standard | Application Received: | 11/14/2013 |

## 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 Orthopedic Surgery 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 is a 65 year old injured worker with industrial injury to right shoulder on 8/24/12. The medical records indicate the claimant status post arthroscopic open rotator cuff repair and decompression 2/7/13. Exam note from 10/7/13 demonstrates report of persistent pain, tenderness, stiffness and weakness. Exam from 10/7/13 demonstrates report of severe supraspinatus tenderness; positive impingement testing in right shoulder. Postoperative MRI of the patient's right shoulder obtained on 7/12/13 demonstrates moderate arthritic changes and chondromalacia of the glenohumeral joint, tendinosis of rotator cuff.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopic evaluation, arthroscopic revision, decompression, distal clavicle resection (Mumford procedure ), rotator cuff debridement and/repair:** Upheld

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

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

**Decision rationale:** According to the Official Disability Guidelines regarding subacromial decompression (acromioplasty), indications for Surgery--Acromioplasty: Criteria for anterior

acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.) 1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. 2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees and pain at night. 3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy; tenderness over rotator cuff or anterior acromial area, and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). 4. Imaging Clinical Findings: Conventional X-rays, AP, and true lateral or axillary view; and Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement. Regarding distal clavicle resection, the Official Disability Guidelines state, "Indications for Surgery--Partial claviculectomy: Criteria for partial claviculectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint: 1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) 2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight or previous grade I or II AC separation. 3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan) and or pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. 4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint or severe DJD of AC joint, or complete or incomplete separation of AC joint, and bone scan is positive for AC joint separation." There is insufficient evidence of imaging findings and failure of conservative care to support medical necessity of the above requested procedure. The request for Right shoulder arthroscopic evaluation, arthroscopic revision, decompression, distal clavicle resection (Mumford procedure), rotator cuff debridement and/repair is not medically necessary and appropriate.

**Pre-operative medical clearance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Home continuous passive motion (CPM) device for initial period of 45 days:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Surgi-Stim unit for initial period of ninety days (if functional and symptomatic benefit at ninety days, purchase of unit):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Coolcare cold therapy unit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.