

<b>Case Number:</b>	CM13-0058163		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	02/03/2012
<b>Decision Date:</b>	04/07/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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:

This 38 year old male machine operator sustained an industrial injury on 2/3/12 when he slipped and fell on a wet floor, landing on his back. The 2/29/12 right shoulder MRI revealed down sloping of the acromion with moderate reduction of the subacromial space, low lying clavicle moderately indenting the supraspinatus muscle and an AC joint effusion. There was moderate anterior subacromial/sub deltoid bursitis with mild roughening of the bursal surface of the supraspinatus, but no evidence of full thickness rotator cuff tear or retraction. The 3/15/12 bilateral upper and lower extremity EMG/NCV studies were normal. The 9/20/13 PM&R report cited continued right shoulder pain and weakness with decreased activities of daily living. Additional complaints included low back pain, neck pain, left shoulder pain, bilateral elbow/wrist pain, thoracic pain, and left knee pain. Objective findings documented global right shoulder tenderness, positive impingement tests, decreased range of motion, and 4/5 right shoulder weakness. Surgery was reported as pending. The 10/30/13 treating physician report documented orthopedic complaints unchanged with right shoulder pain and loss of function. Exam findings documented right shoulder flexion 95 degrees, extension 25 degrees, abduction 90 degrees, adduction 30 degrees, internal rotation 70 degrees, and external rotation 50 degrees. Positive apprehension and impingement signs were reported with 4/5 global shoulder weakness. Under consideration is a request for right shoulder arthroscopic subacromial decompression, distal clavicle resection, and rotator cuff and/or labral debridement with associated pre-operative and post-operative services/items. Records indicated that the patient received 10 visits of physical therapy, acupuncture, and chiropractic treatment in early 2012 and one injection prior to 1/18/13. Treatment of the right shoulder in 2013 has been limited to medication management and home exercise. The patient has been off work since the date of injury for spinal and upper and lower extremity complaints.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopic subacromial decompression, distal clavicle resection, rotator cuff and/or labral debridement as indicated, with pre-op clearance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for rotator cuff repair.

**Decision rationale:** The request under consideration is for right shoulder arthroscopic subacromial decompression, distal clavicle resection, and rotator cuff and/or labral debridement. The California MTUS guidelines do not address rotator cuff repair for chronic injuries. The Official Disability Guidelines for rotator cuff repair or acromioplasty typically require 3 to 6 months of conservative treatment plus painful arc of motion, weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Recent detailed comprehensive non-operative treatment is not documented as having been tried and failed. The most recent comprehensive treatment was documented in late 2012/early 2013. Given the failure to meet guideline criteria, the request for right shoulder arthroscopic subacromial decompression, distal clavicle resection, and rotator cuff and/or labral debridement is not medically necessary.

**Postoperative physical therapy three (3) times a week for four (4) weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 209-211.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** As the right shoulder arthroscopic subacromial decompression, distal clavicle resection, and rotator cuff and/or labral debridement is not medically necessary, the request for post-operative physical therapy 3x4 is also not necessary.

**Continuous passive motion machine for forty-five (45) days:** Upheld

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

**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 passive motion (CPM).

**Decision rationale:** As the right shoulder arthroscopic subacromial decompression, distal clavicle resection, and rotator cuff and/or labral debridement is not medically necessary, the request for continuous passive motion (CPM) machine for 45 days is also not necessary.

**Postoperative Surgi-Stim unit for ninety (90) days with possible purchase:** Upheld

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

**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:** As the right shoulder arthroscopic subacromial decompression, distal clavicle resection, and rotator cuff and/or labral debridement is not medically necessary, the request for cold therapy unit is also not necessary.

**Cold therapy unit (no timeframe given):** Upheld

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

**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:** As the right shoulder arthroscopic subacromial decompression, distal clavicle resection, and rotator cuff and/or labral debridement is not medically necessary, the request for cold therapy unit is also not necessary.