

<b>Case Number:</b>	CM13-0060187		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	03/23/2010
<b>Decision Date:</b>	05/21/2014	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### 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. The expert 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 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/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 claimant is a 57-year-old gentleman who sustained an injury to the left shoulder in a March 23, 2010, work-related accident. On March 20, 2013, the claimant underwent left shoulder arthroscopy, subacromial decompression and open rotator cuff repair with distal clavicle resection. Post-operatively, the claimant reported continued complaints of pain and lack of abduction. A November 4, 2013, MRI scan showed distal supraspinatus full thickness tendon tearing with retraction, indicating a recurrent tear. There was evidence of interval acromioplasty and resection of the distal clavicle. Notes from a follow-up visit dated November 5, 2013, documented continuing subjective complaints of pain and lack of function. Conservative care included physical therapy, the use of anti-inflammatory medications, rest and a corticosteroid injection. This request is for left shoulder arthroscopy with decompression, left shoulder reconstruction, 12 sessions of post-operative physical therapy, a post-operative sling and the use of a cryotherapy unit post-operatively. The medical records provided for review only document that the claimant had one surgery to his left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **LEFT ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION OF SUBACROMIAL SPACE WITH PARTIAL ACROMIOPLASTY: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**Decision rationale:** California ACOEM Guidelines would support the request for shoulder arthroscopy with decompression in this case. In addition to referencing that the claimant has had only one prior shoulder surgery, the claimant's records document recurrent rotator cuff pathology with continued symptoms, which include a lack of improvement in strength and function following the initial surgery. Given the physical examination findings, failure of conservative care and imaging study results in this case, the request for left shoulder arthroscopy with decompression is medically necessary.

**LEFT RECONSTRUCTION OF COMPLETE SHOULDER (ROTATOR) CUFF AVULSION:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

**Decision rationale:** California ACOEM Guidelines would support the need for rotator cuff repair in this case. The claimant underwent one prior rotator cuff repair and imaging performed post-operatively documents evidence of recurrent tearing and lack of function. Given the claimant's history, symptoms and clinical findings, the request for revision surgery would be indicated as medically necessary.

**POST OPERATIVE PHYSICAL THERAPY X12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** According to California MTUS Postsurgical Guidelines, 12 sessions of post-operative physical therapy would be supported in this case. The need for surgical intervention has been established. Therefore, the requested course of physical therapy would be considered medically necessary post-operatively and consistent with guidelines criteria.

**POST OPERATIVE SLING QTY: 1:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Postoperative abduction pillow sling.

**Decision rationale:** California ACOEM Guidelines recommend the use of a sling for acute rotator cuff tears. Also, the Official Disability Guidelines, recommend that slings are indicated for large or massive rotator cuff tearing in the postoperative setting. Given documentation of recurrent rotator cuff tearing in this claimant, the role of a postoperative sling would be supported as medically necessary.

**POST OPERATIVE COLD THERAPY UNIT X 7 DAY RENTAL:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, On-Line Verison, Shoudler Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** California ACOEM Guidelines do not support the use of a cryotherapy device post-operatively in this case. While ACOEM Guidelines recommend the topical application of ice acutely for inflammation, the use of a cryotherapy device to administer cold therapy is not medically necessary.