

<b>Case Number:</b>	CM13-0065042		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	03/13/2013
<b>Decision Date:</b>	03/27/2014	<b>UR Denial Date:</b>	12/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### 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 53-year-old injured worker who is right handed and sustained a repetitive stress/strain injury to the right shoulder with date of injury 3/13/13. The 8/28/13 right shoulder MRI revealed osteoarthritic changes of the glenohumeral joint, moderate hypertrophic osteoarthropathy of the acromioclavicular joint and a partial thickness (60%) undersurface tear of the supraspinatus tendon. No full-thickness rotator cuff tear was identified. The 11/4/13 orthopedic report documented persistent right shoulder pain despite rest and medication. The patient had been offered physical therapy and cortisone injections in the past but declined. Exam findings documented mild global loss of range of motion, severe supraspinatus tenderness, moderate greater tuberosity and AC joint tenderness, mild biceps tenderness, positive subacromial crepitus, no instability, 4/5 global right shoulder strength, normal upper extremity strength and deep tendon reflexes, and positive impingement tests. The orthopedist recommended right shoulder arthroscopic evaluation, arthroscopic rotator cuff debridement and/or repair, subacromial decompression, and distal clavicle resection. Associated requests included pre-operative medical clearance, post-operative rehabilitative therapy 12 sessions, CPM for 45 days, SurgiStim unit for 90 days, and Coolcare cold therapy unit. The 1/22/14 treating physician appeal reviewed the history of injury and treatment and provided guideline and journal citations relative to the surgical and associated services request. Current complaints included persistent right shoulder pain with popping and clicking that increased with reaching and aggravated by cold weather. Impingement and Codman's tests were reported positive.

### 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 rotator cuff debridement and/or repair; subacromial decompression, distal clavicle resection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. 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 California MTUS Chronic Pain Medical Treatment Guidelines do not address shoulder surgeries for chronic injuries. The Official Disability Guidelines for rotator cuff repair of partial thickness tears require 3 to 6 months of conservative treatment, PLUS pain with active arc of motion 90-130 degrees and pain at night, PLUS weak or absent abduction, rotator cuff or anterior acromial tenderness, and positive impingement sign with a positive diagnostic injection test, PLUS clinical imaging findings. Records indicate that this patient has not attempted and failed recent and comprehensive non-operative treatment; conservative treatment has been limited to rest and medications. Objective findings do not document a painful arc of active motion, pain at night, or a positive diagnostic injection. The request for right shoulder arthroscopic evaluation, arthroscopic rotator cuff debridement and/or repair, subacromial decompression, and distal clavicle resection is not medically necessary and appropriate.

**Pre-operative medical clearance with [REDACTED]: 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.

**Supervised post-operative rehabilitative therapy three times a week for four weeks: 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, 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 90 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.

**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.