

<b>Case Number:</b>	CM14-0000750		
<b>Date Assigned:</b>	01/17/2014	<b>Date of Injury:</b>	04/23/2012
<b>Decision Date:</b>	05/12/2014	<b>UR Denial Date:</b>	12/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2014

### 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 is a 59-year-old male who sustained a left shoulder injury on 04/23/12. The clinical records provided for review included a report of an MRI of the left shoulder dated 08/12/13 that documented supraspinatus tendinosis with no rotator cuff pathology, degenerative changes of the AC joint with bicipital tenosynovitis, degenerative changes of the humerus and glenoid rim and minimal subscapularis bursitis. The orthopedic follow-up visit on 11/12/13 noted continued subjective complaints of the shoulder and physical examination showing restricted motion at endpoints, positive impingement and tenderness at the biceps. There was no pain at the AC joint and no evidence of subluxation. Working diagnosis was left shoulder impingement and documented that previous conservative care included medication management, injection therapy, physical therapy and activity restrictions. Surgery was recommended for distal clavicle excision, subacromial decompression and shoulder arthroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **LEFT SHOULDER ARTHROSCOPY:** 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), SECTION INDICATIONS FOR SURGERY - ARTHROSCOPY.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)-- TREATMENT IN WORKERS COMP (TWC), 18TH EDITION; 2013 UPDATES: CHAPTER SHOULDER: ARTHROSCOPY.

**Decision rationale:** The California ACOEM Guidelines do not address left shoulder arthroscopy. The Official Disability Guidelines describe arthroscopy as the method using an arthroscope allowing the physician to see inside the shoulder joint and perform surgery. As the remaining parts of the surgical procedure are recommended as medically necessary, the approach through arthroscopy of the left shoulder would be recommended as medically necessary.

**SUBACROMIAL DECOMPRESSION:** 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), SECTION INDICATIONS FOR SURGERY - ACROMIOPLASTY.

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

**Decision rationale:** The request for subacromial decompression based on the ACOEM Guidelines is recommended as medically necessary. The ACOEM Guidelines indicate that surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least three to six months before considering surgery. The need for subacromial decompression is indicated based upon the employee's current physical examination findings and failed conservative care including injection therapy over the past six months.

**DISTAL CLAVICLE EXCISION REPAIR:** 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), SECTION INDICATIONS FOR SURGERY - PARTIAL CLAVICULECTOMY.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)-- TREATMENT IN WORKERS COMP (TWC), 18TH EDITION, 2013 UPDATES: SHOULDER PROCEDURE - PARTIAL CLAVICULECTOMY.

**Decision rationale:** The California MTUS and ACOEM Guidelines do not address this procedure. Based upon the Official Disability Guidelines, the request for distal clavicle excision in this case would also be supported. The employee's clinical picture is consistent with significant degenerative changes of the AC joint. There is documentation of failed conservative care. Given the nature of the surgical process in question and the employee's positive imaging

findings, the role of a distal clavicle excision at this stage in the employee's course of care would be supported.

**POST OPERATIVE PHYSICAL THERAPY X 8:** Overturned

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

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

**Decision rationale:** The California MTUS Postsurgical Rehabilitative Guidelines support the request for eight initial sessions of physical therapy. The Postsurgical Guidelines recommend up to 24 therapy visits following arthroscopic approach for the proposed surgery. The specific request for eight sessions is medically necessary.

**DME: COLD UNIT RENTAL X 7 DAYS:** 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), SECTION CONTINUOUS-FLOW CRYOTHERAPY.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)-- TREATMENT IN WORKERS COMP (TWC), 18TH EDITION, 2013 UPDATES: SHOULDER PROCEDURE - CONTINUOUS-FLOW CRYOTHERAPY.

**Decision rationale:** The California MTUS and ACOEM Guidelines do not address this request. When looking at Official Disability Guidelines, seven day rental of a cryotherapy device is medically necessary based on the need of surgical intervention in this case, specific request would be deemed necessary.