

<b>Case Number:</b>	CM14-0003072		
<b>Date Assigned:</b>	01/29/2014	<b>Date of Injury:</b>	08/10/2010
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2014

### 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 Texas. 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 injured worker is a 67-year-old female who reported an injury to her right shoulder on 01/07/13. The clinical note dated 07/29/13 indicates the injured worker complaining of low back and right shoulder pain. The injured worker demonstrated no reflex deficits throughout the lower extremities at that time. An MRI (magnetic resonance imaging) of the right shoulder dated 11/05/13 revealed a partial thickness under surface tear of the supraspinatus tendon. The clinical note dated 11/18/13 indicates the injured worker stating the initial injury occurred on 08/10/10 when she had a slip and fall. The injured worker continued with complaints of persistent right shoulder pain. Upon exam, the injured worker was able to demonstrate 150 degrees of right shoulder flexion, 40 degrees of extension, 150 degrees of abduction, 40 degrees of adduction, 90 degrees of external rotation, and 60 degrees of internal rotation. The injured worker rated the pain as 6/10. Severe tenderness was identified at the suprapinatus with moderate tenderness at the greater tuberosity. 4/5 strength was identified throughout the right shoulder. The clinical note dated 12/17/13 indicates the injured worker continuing with right shoulder complaints. The clinical note dated 01/08/13 indicates the injured worker continuing with muscle guarding and tenderness. Range of motion deficits continued at the right shoulder. No evidence of swelling, atrophy, or deformity was identified. The previous review dated 12/23/13 resulted in a denial for a rotator cuff repair with associated treatments as no documentation was submitted regarding the injured worker's completion of any conservative treatments.

### 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 RIGHT SHOULDER DECOMPRESSION, DISTAL CLAVICULAR RESECTION, ROTATOR CUFF DEBRIDEMENT AND/OR REPAIR AS INDICATED.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER AND SURGERY CHAPTER

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** The request for a right shoulder arthroscopic evaluation, arthroscopic right shoulder decompression, distal clavicular resection, rotator cuff debridement and/or repair is non-certified. The documentation indicates the injured worker complaining of right shoulder pain with associated range of motion deficits. An arthroscopic decompression as well as rotator cuff debridement/repair is indicated provided that the injured worker meets specific criteria to include completion of a 3 month course of conservative therapy as well as the injured worker having undergone an injection. No information was submitted regarding the injured worker's therapeutic interventions outside of a home exercise program. Given that no documentation was submitted confirming the injured worker's 3 month course of formal therapy followed by an injection, this request is not indicated.

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, PRE-OPERATIVE EXAM.

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

**POST-OPERATIVE REHABILITATIVE THERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS:** Upheld

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

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

**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 FORTY-FIVE (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 base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER CHAPTER, CONTINUOUS PASSIVE MOTION DEVICE.

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

**SURGI-STIM UNIT FOR NINETY (90) DAYS, THEN PURCHASE: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL UNIT Page(s): 118-120.

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

**COOL CARE 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 base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER CHAPTER, CONTINUOUS CRYO-THERAPY.

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