

<b>Case Number:</b>	CM14-0005330		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	04/19/2011
<b>Decision Date:</b>	07/03/2014	<b>UR Denial Date:</b>	12/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2014

### 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, has a Spine Fellowship 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 patient is a 59-year-old male who has submitted a claim for right shoulder pain s/p arthroscopy (1998) associated with an industrial injury date of April 19, 2011. Medical records from 2012 to 2013 were reviewed. Patient complained of persistent right shoulder pain, rated 7/10 in severity, associated with tenderness, stiffness, and weakness. This resulted to difficulty in lifting, pushing, pulling, and sleeping on the right side. Range of motion of the right shoulder was restricted on all planes. Tenderness and subacromial crepitus were present. Motor strength of the right upper extremity was graded 4/5. Sensation and reflexes were normal. AC joint compression test, Impingement I, Impingement II, and Impingement III tests were all positive. Most of the progress reports were handwritten and somewhat illegible. MR arthrogram of the right shoulder, dated 1/17/13, revealed postoperative change to the rotator cuff, and subacromial bursitis with moderate osteoarthritic change. MR arthrogram of the right shoulder, dated 5/14/13, revealed a small tear of the infraspinatus tendon with acromioclavicular degenerative joint disease. Treatment to date has included subacromial decompression, arthroscopy, and debridement of the right shoulder on 9/10/98; left shoulder subacromial decompression (Mumford) on 11/9/11, 2 sessions of physical therapy to the right shoulder, acupuncture, and medications such as Ultram, Anaprox, and Vicodin. Utilization review from December 11, 2013 denied the request for right shoulder arthroscopic evaluation because there was no documentation on failure of conservative management and any evidence of impingement. Therefore, all of the associated services such as, arthroscopic subacromial decompression, arthroscopic rotator cuff debridement, pre-operative medical clearance, post operative physical therapy, durable medical equipment, CPM, Surgi-Stim Unit, cold therapy unit, and large abduction pillow were likewise denied.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **RIGHT SHOULDER ARTHROSCOPIC EVALUATION:** 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:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Section, Diagnostic Arthroscopy.

**Decision rationale:** CA MTUS ACOEM Practice Guidelines Chapter 9 supports surgical intervention for patients who have: (1) red flag conditions; (2) activity limitation for more than four months, plus existence of a surgical lesion; (3) failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; (4) clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term, from surgical repair. In addition, ODG states that diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. In this case, patient had a history of subacromial decompression, arthroscopy, and debridement of the right shoulder on 9/10/98. Patient was status quo until there was recurrence of symptoms in 2010 when he had an industrial accident. He complained of persistent right shoulder pain associated with tenderness and stiffness. This was corroborated by objective findings of restricted range of motion, weakness, crepitation, and positive provocative test. MR arthrogram of the right shoulder, dated 5/14/13, revealed a small tear of the infraspinatus tendon with acromioclavicular degenerative joint disease. It was cited that patient is a surgical candidate due to failure of conservative management. However, patient only underwent two sessions of physiotherapy; hence, there was no exhaustion of conservative care. The guideline criteria were not met. Therefore, the request for RIGHT SHOULDER ARTHROSCOPIC EVALUATION is not medically necessary.

### **ARTHROSCOPIC SUBACROMIAL DECOMPRESSION:** 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:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Section, Surgery for Impingement Syndrome.

**Decision rationale:** CA MTUS ACOEM Practice Guidelines Chapter 9 supports surgical intervention for patients who have: (1) red flag conditions; (2) activity limitation for more than four months, plus existence of a surgical lesion; (3) failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; (4) clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term, from surgical repair. In this case, patient had a history of

subacromial decompression, arthroscopy, and debridement of the right shoulder on 9/10/98. Patient was status quo until there was recurrence of symptoms in 2010 when he had an industrial accident. He complained of persistent right shoulder pain associated with tenderness and stiffness. This was corroborated by objective findings of restricted range of motion, weakness, crepitation, and positive provocative test. It was cited that patient is a surgical candidate due to failure of conservative management. However, patient only underwent two sessions of physiotherapy; hence, there was no exhaustion of conservative care. Furthermore, ODG states that a criterion for decompression should include imaging finding of impingement. However, patient's MR arthrogram of the right shoulder, dated 5/14/13, revealed a small tear of the infraspinatus tendon with acromioclavicular degenerative joint disease. There was no note of impingement. The guideline criteria were not met. Therefore, the request for ARTHROSCOPIC SUBACROMIAL DECOMPRESSION is not medically necessary.

**ARTHROSCOPIC ROTATOR CUFF DEBRIDEMENT AND/OR REPAIR: 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:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Section, Surgery for Rotator Cuff Repair.

**Decision rationale:** CA MTUS ACOEM Practice Guidelines Chapter 9 supports surgical intervention for patients who have: (1) red flag conditions; (2) activity limitation for more than four months, plus existence of a surgical lesion; (3) failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; (4) clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term, from surgical repair. In this case, patient had a history of subacromial decompression, arthroscopy, and debridement of the right shoulder on 9/10/98. Patient was status quo until there was recurrence of symptoms in 2010 when he had an industrial accident. He complained of persistent right shoulder pain associated with tenderness and stiffness. This was corroborated by objective findings of restricted range of motion, weakness, crepitation, and positive provocative test. It was cited that patient is a surgical candidate due to failure of conservative management. However, patient only underwent two sessions of physiotherapy; hence, there was no exhaustion of conservative care. Furthermore, ODG states that criterion for rotator cuff repair should include a diagnosis of full thickness rotator cuff tear. However, patient's MR arthrogram of the right shoulder, dated 5/14/13, revealed a small tear of the infraspinatus tendon. Full-thickness tear was not noted. The guideline criteria were not met. Therefore, the request for ARTHROSCOPIC ROTATOR CUFF DEBRIDEMENT AND/OR REPAIR is not medically necessary.

**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 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.

**POST-OPERATIVE PHYSICAL THERAPY 12 SESSIONS:** 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.

**CPM MACHINE X 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 X 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.

**LARGE ABDUCTION PILLOW:** 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.