

<b>Case Number:</b>	CM14-0126184		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	02/15/2008
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/08/2014

### 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 Orthopaedic 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:

This 44-year-old female waitress sustained an industrial injury on 11/25/09, relative to a slip and fall. The patient underwent right shoulder extensive labral and rotator cuff debridement, SLAP repair, and distal clavicle resection on 3/3/11. The patient was status post right L5/S1 microdiscectomy on 9/30/13. The 6/27/14 orthopedic report indicated the patient had increasing right shoulder pain. There was pain with reaching away from the body and at night. Right shoulder weakness was reported trying to lift above shoulder level. The patient had been treated with physical therapy, soft tissue mobilization and anti-inflammatories with persistent symptoms. The 7/15/14 right shoulder MRI findings documented partial thickness bursal surface tear of the supraspinatus measuring 5 mm just beneath the tip of the acromion. There was mild acromioclavicular joint arthropathy, supraspinatus tendinopathy, possible subacromial/subdeltoid bursitis, and distention of the biceps tendon sheath suspicious for tenosynovitis. The 7/18/14 medical report cited continuing shoulder and neck pain. The physical exam documented shoulder range of motion as abduction 100, flexion 160, internal rotation 20, external rotation 40, extension 50, and adduction 50 degrees. Jobe's, Hawkin's, impingement, cross body adduction, and Neer's tests were positive on the right. The diagnosis included right shoulder symptomatic rotator cuff tear and impingement with biceps tenosynovitis. The treatment plan requested authorization for right shoulder arthroscopy, rotator cuff repair, and subacromial decompression.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy, RC Repair, SAD, Debride/Synovectomy, Biceps Tenodesis:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Shoulder Chapter.

**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, Surgery for rotator cuff repair, Surgery for impingement syndrome.

**Decision rationale:** The California MTUS guidelines provide a general recommendation for rotator cuff repair and impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The ODG provide more specific indications that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. The criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. The guideline criteria have not been met. There is no detailed documentation that recent comprehensive guideline-recommended conservative treatment had been tried and failed. Records indicate that physical medicine treatment has been limited to modalities and manual therapies, with no evidence of exercise or steroid injections. There is no documentation of a positive diagnostic injection test. Therefore, this request is not medically necessary.

**Purchase Ultra Sling, Abduction Pillow:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205-213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

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

**7 day rental Polar Care:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy.

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

**12 physical therapy:** Upheld

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

**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.