

<b>Case Number:</b>	CM14-0023741		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	05/19/2011
<b>Decision Date:</b>	08/02/2014	<b>UR Denial Date:</b>	02/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### 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 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 claimant is a 39-year-old male who sustained a vocational injury on May 19, 2011, while working in a car wash. Two cars collided, and one car struck the claimant, throwing him into a wall. The records available for review note that the claimant underwent right shoulder surgery in November 2011. The claimant's current working diagnosis is right shoulder partial rotator cuff tear, rotator cuff tendinosis, SLAP tear with a paralabral cyst, and right shoulder pain. There is documentation that the December 10, 2013, MR arthrogram identified a partial tear of the distal infraspinatus tendon at its humeral insertion, supraspinatus tendinosis, SLAP tear with a small paralabral cyst overlying the posterior aspect of the superior labral rim, and a 1.6 centimeter synovial cyst or ganglion over the anterior-inferior bony glenoid. In a July 8, 2014, letter, the treating physician noted that the claimant reported right shoulder pain, which wakes him at night frequently, and experiences pain that increased with lifting, pushing, pulling and reaching. The claimant also reported neck pain. Physical examination of the right shoulder showed limited range of motion in all planes, tenderness over the supraspinatus tendon, over the acromioclavicular joint, over the greater tuberosity and over the biceps tendon, and subacromial crepitus. Orthopedic tests were positive. The letter documents that the claimant failed conservative treatment; however, the type or length of conservative care is not specified. This review request is for a right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, distal clavicle resection and labral debridement or repair as indicated, as well as for the following perioperative services - preoperative medical clearance, 12 sessions of post-operative physical therapy, a 45-day rental of a CPM unit, a 90-day rental of a surgical stimulation unit; and a 90-day rental of a cold therapy unit.

### 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 SUBACROMIAL DECOMPRESSION, DISTAL CLAVICLE RESECTION, LABRAL DEBRIDEMENT OR REPAIR AS INDICATED.:** Upheld

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

**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) Treatment in Worker's Comp; 2013 Updates: Shoulder chapter.

**Decision rationale:** Based on California ACOEM, and Official Disability Guidelines, the request for right shoulder arthroscopic evaluation arthroscopic subacromial decompression, distal clavicle resection, labral repair or debridement is not supported as medically necessary. Under ACOEM Guidelines criteria, three to six months of continuous conservative treatment is recommended before considering surgery. The conservative care should include formal physical therapy, a home exercise program, anti-inflammatory medications, and a diagnostic/ therapeutic injection. The reviewed records do not document conservative care. In addition, while the records reference the December 2013 MR arthrogram, the actual report is not available to confirm pathology that may be correctable by surgical intervention. Absent conservative care and imaging studies supporting pathology requiring surgical repair, this request is not indicated as medically necessary.

**PRE-OP 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

**Decision rationale:** The request for right shoulder arthroscopic evaluation arthroscopic subacromial decompression, distal clavicle resection, labral repair or debridement is not supported as medically necessary. Therefore, the request for preoperative medical clearance is not medically necessary.

**POST -OP PT 3 X 4:** 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.

**Decision rationale:** The request for right shoulder arthroscopic evaluation arthroscopic subacromial decompression, distal clavicle resection, labral repair or debridement is not supported as medically necessary. Therefore, the request for 12 sessions of post-operative physical therapy is not medically necessary.

**CPM DEVICE RENTAL FOR 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.

**Decision rationale:** The request for right shoulder arthroscopic evaluation arthroscopic subacromial decompression, distal clavicle resection, labral repair or debridement is not supported as medically necessary. Therefore, the request for a 45-day, post-operative rental of a CPM device is not medically necessary.

**SURGI STIM UNIT RENTAL FOR 90 DAYS:** 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 Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The request for right shoulder arthroscopic evaluation arthroscopic subacromial decompression, distal clavicle resection, labral repair or debridement is not supported as medically necessary. Therefore, the request for a 90-day, post-operative rental of a Surgical Stim unit is not medically necessary.

**COOLCARE COLD THERAPY UNIT RENTAL FOR 90 DAYS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): online. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder chapter, Continuous-flow cryotherapy.

**Decision rationale:** The request for right shoulder arthroscopic evaluation arthroscopic subacromial decompression, distal clavicle resection, labral repair or debridement is not supported as medically necessary. Therefore, the request for a 90-day, post-operative rental of a cold therapy unit is not medically necessary.

