

<b>Case Number:</b>	CM14-0037393		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	08/21/2012
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2014

### 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 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, a 37-year-old female, sustained a right shoulder injury on 08/21/12 while working as a line cook carrying boxes of lettuce. The report of an MR arthrogram of the right shoulder dated August 26, 2013, showed a subtle non-displaced tear of the superior labrum with subjacent small paralabral cyst extending to the suprascapular notch region, measuring 2.0 x 1 centimeters. The biceps tendon and the biceps anchor were grossly intact. There was tendinosis/strain and/or small minimal partial thickness tear of the distal supraspinatus and infraspinatus tendons noted without evidence of full thickness rotator cuff tear. There was mild narrowing of the acromiohumeral interval noted. The report of x-rays of the right shoulder dated November 18, 2013, were noted to be within normal limits. The most recent office note for review is from [REDACTED] dated March 17, 2014 and notes the claimant had high pain ratings in the neck, right shoulder, right hip, right leg, and the fingers of the right hand with swelling. The claimant was also noted to have swelling in her face with headaches and spasm of the complete right side of her body. There were no specific physical exam findings of the right shoulder documented at that visit. However, the February 17, 2014 examination by [REDACTED] noted that the claimant had a positive Hawkins test and weakness to abduction and external rotation but the laterality was not noted. The records provided for review did not contain documentation of previous surgical intervention. The claimant's working diagnosis is right shoulder sprain/strain with impingement. Conservative treatment to date was documented as six chiropractic treatments.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder diagnostic arthroscopy and surgery, subacromial decompression (SAD) and tissue repair labrum or rotator cuff as indicated and able.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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; 18th Edition, 2014 Updates; Shoulder chapter.

**Decision rationale:** The California MTUS ACOEM Guidelines and supported by the Official Disability Guidelines do not recommend right shoulder diagnostic arthroscopy, subacromial decompression and tissue repair labrum or rotator cuff. The ACOEM Guidelines and Official Disability Guidelines support acromioplasty for impingement syndrome and repair of SLAP tears only if there has been documented failed conservative treatment in the form of anti-inflammatory and/or formal physical therapy along with a home exercise program. Currently, there is no documentation that the claimant has attempted and failed a course of anti-inflammatory, formal physical therapy, or a home exercise program. In addition, it may also be reasonable to proceed with a diagnostic and therapeutic subacromial and/or glenohumeral joint injection in an attempt to determine pain generators and subsequently give prognosis for the requested surgical intervention. The ACOEM Guidelines also recommend clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. There is no diagnostic imaging confirming that the claimant has any rotator cuff pathology. Therefore, based on the documentation presented for review and the ACOEM Guidelines and Official Disability Guidelines the request for a right shoulder diagnostic arthroscopy and surgical subacromial decompression with tissue repair of the labrum and rotator cuff repairs as indicated cannot be considered medically necessary.

**Shoulder sling with abduction pillow: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation (ODG) Treatment in Worker's Comp: 2014 Updates, 18th Edition; Shoulder chapter, Postoperative abduction pillow sling.

**Decision rationale:** The request for surgical intervention has been deemed not medically necessary and subsequently the request for a shoulder sling with abduction pillow cannot be considered medically necessary.

**Post-operative physical therapy 2 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 surgical intervention has been deemed not medically necessary and subsequently the request for postoperative physical therapy cannot be considered medically necessary.

**Cold therapy unit 30 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder; Am J Sports Med. 1996 Mar-Apr 24 (2): 193-5; AJSM, 2004, 32 pages 251-261.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation (ODG) Shoulder chapter, Continuous-flow cryotherapy.

**Decision rationale:** The proposed surgery cannot be recommended as medically necessary. Therefore, the request for a cold therapy unit is not necessary.

**Pain pump:** 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 (ODG) Shoulder chapter, Postoperative pain pump.

**Decision rationale:** The request for surgical intervention has been deemed not medically necessary and subsequently the request for postoperative pain pump cannot be considered medically necessary.