

<b>Case Number:</b>	CM14-0095891		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	08/22/2013
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	06/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2014

### 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 34-year-old female who sustained an injury to the right shoulder on 08/22/13. Clinical records provided for review include the 07/09/14 follow up report noting continued complaints of pain in the shoulder. Physical examination demonstrated tenderness with overhead activities, range of motion of 120 degrees of forward flexion and 100 degrees of abduction, described as guarded. Working assessment on that date was possible adhesive capsulitis with shoulder impingement syndrome. Recommendations were for shoulder arthroscopy, subacromial decompression, rotator cuff repair, SLAP repair, open biceps tenodesis with the postoperative use of a sling, cryotherapy device and physical therapy. There is documentation of a prior wrist MRI report but no documentation of recent imaging of the shoulder. In an assessment report dated 02/27/14, it is documented that an MRI scan of the claimant's shoulder was read as "negative." The report also documents that the claimant has failed conservative care including physical therapy, medication management and prior corticosteroid injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative abduction sling:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Postoperative abduction pillow sling Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. (Ticker, 2008) Other Medical Treatment Guideline or Medical Evidence.

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

**Post operative physical therapy x12 (unspecified frequency,duration):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

**Right shoulder arthroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**Decision rationale:** The medical records provided for review do not contain any imaging reports to determine the presence of surgical pathology and the physician's office note documents that a prior MRI scan to the shoulder was "negative." While the records describe that the claimant had a guarded examination and failed conservative care, without documentation of imaging demonstrating internal pathology, the acute need of shoulder arthroscopy and the multiple listed surgical processes would not be indicated. The request for right shoulder arthroscopy is not medically necessary and appropriate.

**Rotator cuff repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** Based on California MTUS ACOEM Guidelines, the request for rotator cuff repair would also not be recommended. The claimant is documented to have negative imaging of the shoulder failing to demonstrate bicipital labral rotator cuff or inflammatory impingement findings. The need for surgical process would not be supported. The request for a rotator cuff repair is not medically necessary and appropriate.

**SLAP repair:** 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): 207-209.

**Decision rationale:** Based on California MTUS ACOEM Guidelines, the request for SLAP repair is also not recommended as medically necessary. The claimant has negative imaging of the shoulder failing to demonstrate bicipital labral rotator cuff or inflammatory impingement findings. The need for surgical process would not be supported. The request for SLAP repair is not medically necessary and appropriate.

**Open biceps tenodesis.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** Based on California MTUS ACOEM Guidelines, the request for open biceps tenodesis in this case would not be indicated. The claimant has negative imaging of the shoulder failing to demonstrate bicipital labral rotator cuff or inflammatory impingement findings. The need for surgical process would not be supported. The request for open biceps tenodesis is not medically necessary and appropriate.

**Subacromial decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** Based on California MTUS ACOEM Guidelines, the request for subacromial decompression would also not be recommended as medically necessary. There is no imaging studies/reports to demonstrate bicipital labral rotator cuff or inflammatory

impingement findings. The need for surgical process would not be supported. The request for a subacromial decompression is not medically necessary and appropriate.

**Ice machine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 201-205, 555-556.

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