

<b>Case Number:</b>	CM14-0098835		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	12/18/2013
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	05/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/27/2014

### 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 in Orthopedic Surgery, has a subspecialty in Hand Surgery and is licensed to practice in Texas and Georgia. 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 injured worker is a 35-year-old male who reported an injury on 12/18/2013 after stacking heavy bags of grinders in a pallet. The injured worker reportedly sustained an injury to his right upper extremity. The injured worker's treatment history included medications, physical therapy, injections, and a home exercise program. The injured worker was evaluated on 05/05/2014. It was documented that the injured worker had ongoing neck, right shoulder, and elbow pain complaints. It was documented that the injured worker had temporary pain relief from the previous subacromial right shoulder injection. It was noted that the injured worker was not responsive to physical therapy. Physical findings included tenderness to palpation of the acromioclavicular joint with no evidence of instability, and range of motion described as 160 degrees in abduction, 40 degrees in adduction, 40 degrees in extension, 90 degrees in internal and external rotation, and 160 degrees in flexion. A request was made for arthroscopic subacromial decompression and excisional acromioclavicular joint arthroplasty as the patient was symptomatic of bursitis and acromioclavicular joint pain. Request for Authorization Forms for surgical intervention and associated postsurgical care and followup visits were submitted on 05/05/2014. A Letter of Appeal dated 06/10/2014 documented that the request was previously reviewed and received an adverse determination due to lack of an imaging study. It was noted that the requested subacromial decompression would serve as a corrective surgical procedure to manage impingement and maintain joint positioning, increase mobility, and restore shoulder function. The injured worker underwent an MRI on 07/16/2014. It was noted that the injured worker had moderate tendinosis of the supraspinatus and infraspinatus tendon with a posterior labral tear and moderate acromioclavicular joint degenerative changes with moderate hypertrophy and narrowing of the coracoacromial arch with moderate impression on the underlying supraspinatus tendon and muscle body.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Right Shoulder Arthroscopic Subacromial Decompression and Mumford Procedure Qty: 1: Overturned**

**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): 209-212.

**Decision rationale:** The requested Right Shoulder Arthroscopic Subacromial Decompression and Mumford Procedure Qty: 1 is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommends surgical intervention for shoulder injuries involving impingement for patients who have physical findings consistent with a diagnosis confirmed by pathology identified on an imaging study that have failed to respond to conservative treatments. The clinical documentation submitted for review does indicate that the injured worker has physical findings consistent with impingement syndrome corroborated by an imaging study. It is noted that the injured worker has failed to respond to multiple conservative treatments to include physical therapy, medications, and subacromial injections. Therefore, surgical intervention would be indicated in this clinical situation. As such, the requested Right Shoulder Arthroscopic Subacromial Decompression and Mumford Procedure Qty: 1 is medically necessary and appropriate.

### **Motorized hot/cold unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

**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 Flow Cryotherapy.

**Decision rationale:** The requested Motorized hot/cold unit is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address this request. The Official Disability Guidelines recommend a continuous flow cryotherapy unit for up to 7 days following shoulder surgery to assist with pain management and inflammation postsurgically. The clinical documentation submitted for review does support that the injured worker is a surgical candidate. However, the request as it is submitted does not specifically identify whether this durable medical equipment is for rental or purchase. As a rental period of 7 days would be supported and purchase of the equipment would not, the request as it is written would not be supported by guideline recommendations. As such, the requested Motorized hot/cold unit is not medically necessary or appropriate.

**Pro-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 DISABILITIES GUIDELINES.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Surgery, Post-Operative sling with abduction pillow.

**Decision rationale:** The requested Pro-Sling with abduction pillow is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this type of immobilization. The Official Disability Guidelines recommend a Pro-Sling with abduction pillow for massive rotator cuff repairs. The clinical documentation submitted for review does indicate that the injured worker is a candidate for impingement syndrome surgery to be repaired arthroscopically. The use of this type of immobilization is not supported for arthroscopically repaired shoulder injuries. There are no exceptional factors noted within the documentation to support extending treatment beyond the guideline recommendations. As such, the requested Pro-Sling with abduction pillow is not medically necessary or appropriate.

**Sprix nasal spra: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Sprix (ketorolac tromethamine nasal Spray).

**Decision rationale:** The requested Sprix nasal spra is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address this request. The Official Disability Guidelines recommend this medication for short term management of moderate to moderately severe acute pain requiring analgesia at the opioid level. The clinical documentation submitted for review does indicate that the injured worker is a surgical candidate and would benefit from opioid level analgesia. However, the use of this medication should be for the shortest duration, not to exceed 5 days. The request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Sprix nasal spra is not medically necessary or appropriate.

**Post-operative physical therapy two times a week for four weeks: Overturned**

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

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

**Decision rationale:** The requested Post-operative physical therapy two times a week for four weeks is medically necessary and appropriate. The California Medical Treatment Utilization Schedule recommends up to 24 visits of physical therapy in the postsurgical care of impingement syndrome surgery. The California Medical Treatment Utilization Schedule recommends up to half the number of recommended visits as an initial course of treatment to establish efficacy of treatment. The requested 8 visits falls within that recommendation. As the clinical documentation submitted for review does support that the injured worker is a surgical candidate, postoperative physical therapy would be supported in this clinical situation. As such, the requested Post-operative physical therapy two times a week for four weeks is medically necessary and appropriate.