

<b>Case Number:</b>	CM14-0184188		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	04/13/2011
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2014

### 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:

46 year old male claimant with an industrial injury dated 04/13/11. The patient is status post an arthroscopic superior labral tear repair in 2011, and an arthroscopic Bankart procedure in 2012. MR arthrogram of the left shoulder dated 07/02/14 reveals a retear of the anterior superior glenoid labrum at the 12 o'clock position. Exam note 09/22/14 states the patient returns with ongoing left-sided shoulder pain, weakness, and stiffness. The patient rates the pain a 3-7/10. Upon physical exam the patient demonstrated a decreased range of motion on the left. Range of motion was noted as 150' forward flexion, extension og 50', 150' abduction, 40' adduction, 80' external rotation, and 40' internal rotation. On the left there was evidence of severe supraspinatus tenderness, moderate greater tuberosity tenderness, mild biceps tendon tenderness, and mild AC joint tenderness. Muscle strength is noted as 4/5 on the left and 5/5 on the right in which the testing on the left was affected by pain. The patient completed a positive AC joint compression test, and impingement I/ II/ III. Diagnosis is noted as left shoulder impingement syndrome. Treatment includes a left shoulder arthroscopic surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-Operative Medical Clearance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.brighamandwomens.org/gms/Medical/preopprotocols.aspx>

**Decision rationale:** The California MTUS and Official Disability Guidelines are silent on the issue of preoperative clearance. Alternative guidelines were therefore referenced. The alternative guidelines states that patients greater than age 40 require a CBC; males require an ECG if greater than 40 and female is greater than age 50; this is for any type of surgery. In this case, the claimant is 46 years old and does not have any evidence in the cited records from 9/22/14 of significant medical comorbidities to support a need for preoperative clearance. Therefore, this request is not medically necessary.

**Post-Operative Home CPM Machine for the Left Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 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, CPM

**Decision rationale:** The California MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis in the cited record of 9/22/14, the request is not medically necessary.

**Post-Operative Surgi-stim unit for the Left Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 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, Electrical stimulation

**Decision rationale:** The California MTUS/ACOEM is silent on the issue of electrical stimulation of the shoulder. Per the Official Disability Guidelines, Shoulder section, electrical stimulation, "Not recommended. For several physical therapy interventions and indications (eg, thermotherapy, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy." As the guidelines do not recommend electrical stimulation, the request is not medically necessary.

**Post-Operative Coolcare Cold Therapy Unit for the Left Shoulder for an initial period of 90 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 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, Continuous Flow Cryotherapy

**Decision rationale:** The California MTUS ACOEM is silent on the issue of shoulder cryotherapy. According to Official Disability Guidelines, Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case, there is a request for 90 days postoperatively for the cryotherapy unit. As the request exceeds the 7 day recommendation, the request is not medically necessary.