

<b>Case Number:</b>	CM14-0192002		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	04/02/2007
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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:

50 year old female claimant with an industrial injury dated 04/02/07. Ultrasound of the bilateral shoulders dated 10/30/13 provides evidence for no apparent rotator cuff tear or bursal enlargement. MRI of the right shoulder dated 11/12/13 reveals no full thickness tear of the rotator cuff. Conservative treatments include medications, corticosteroid injections, and physical therapy session all providing little pain relief. Exam note 08/18/14 states the patient returns with right shoulder pain. Upon physical exam there was evidence of tenderness surrounding the AC joint, supraspinatus, greater tuberosity, and biceps tendon. Range of motion is noted as a forward flexion and abduction of 90', external rotation of 80', and extension, adduction, and internal rotation of 40'. There was evidence of subacromial crepitus present, and the patient demonstrated pain throughout the testing. The patient's muscle strength is noted as 4/5, and reflexes were noted as 2+. Exam note 08/28/14 states the patient continues to have right shoulder pain. Current medications include Lortab. The patient completed a limited range of motion, and a positive Impingement and Hawkins test. Treatment includes a right shoulder arthroscopic surgery, and 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 decompression with distal clavicle resection, rotator cuff and/or labral debridement: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Surgery for Rotator Cuff Tear

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 8/18/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 8/18/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. There is no evidence of a rotator cuff tear from the MRI of 11/12/13. Therefore the determination is for non-certification for the requested procedure.

**Purchase of CoolCare cold therapy unit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**45 days rental of home continuous passive motion device:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**90 days rental of Surgi-Stim unit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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