

<b>Case Number:</b>	CM14-0206911		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	04/12/2006
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	11/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 63-year-old male who reported injury on 04/12/2006. The mechanism of injury was not provided. The documentation of 11/04/2014 revealed the injured worker had right shoulder pain over the lateral aspect of the shoulder in the subacromial area. The physical examination of the right shoulder revealed scars from a prior arthroscopy. There was tenderness in the bicipital groove, and slight in the lateral supraspinatus and along the tuberosity. Active range of motion and abduction was 80 degrees, anterior flexion 100 degrees, extension 40 degrees, external rotation 60 degrees, and adduction of 20 degrees. The drop arm test in both pronation and supination with and without resistance demonstrated a functional rotator cuff. The biceps and triceps strength was 5/5, and the grasp was slightly weak. The injured worker had a cubital tunnel that was positive in the distal ulnar forearm and the carpal and Guyon's canal. Tinel's testing was negative. The documentation indicated the injured worker had an MRI on 09/17/2013, with significant tendonitis in the shoulder, with a chronic SLAP tear versus postsurgical changes. There were postsurgical findings of subacromial decompression with a Mumford type procedure with an acromioplasty. The physician indicated due to the persistent symptoms and short response to cortisone injections, the injured worker was a candidate for a revision arthroscopy of the right shoulder. The diagnoses included unspecified disorder, bursa tendon, and shoulder. The treatment plan included a right shoulder revision arthroscopic procedure and continuation of medications, as well as a postsurgical Polar Care unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Revision Arthroscopic procedure:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214, 211, 204, and 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter Diagnostic Arthroscopy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214, 211, 204, and 210-211.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have a failure to increase range of motion and strength of musculature in the shoulder after exercise programs and who have clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. For injured workers with a partial thickness or small full thickness tear, impingement surgery is reserved for cases failing conservative care therapy for 3 months and who have imaging evidence of rotator cuff deficit. For surgery for impingement syndrome, there should be documentation of conservative care including cortisone injections for 3 to 6 months before considering surgery. The clinical documentation submitted for review indicated the injured worker had minimal benefit from an injection. The specific conservative care and the duration of care, with the exception of the injection, were not provided. The official MRI was not provided for review. The request as submitted failed to indicate the specific procedures being requested. Given the above, the request for Surgery: Right Shoulder Revision Arthroscopic procedure: is not medically necessary.

**Vascutherm Intermittent, PCD for DVT- Right Shoulder, 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 (ODG) Shoulder Chapter, Continuous-flow cryotherapy.

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

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.