

<b>Case Number:</b>	CM14-0207817		
<b>Date Assigned:</b>	12/19/2014	<b>Date of Injury:</b>	06/04/2013
<b>Decision Date:</b>	02/11/2015	<b>UR Denial Date:</b>	11/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/11/2014

### 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:

According to the records made available for review, this is a 30-year-old male with a 6/4/13 date of injury. At the time (10/24/14) of request for authorization for left shoulder arthroscopic subacromial decompression, left wrist arthroscopic decompression, associated surgical services: post-operative DME Purchase: shoulder immobilizer/sling, associated surgical services: post-operative DME Rental: cold therapy times 7 days, post-operative DME rental: Continuous Passive Motion times 21 days, post-operative physical therapy 3 times 8, and associated Surgical Services: pre-operative labs: CBC, PT, PTT, urinalysis, CMP, there is documentation of subjective (left shoulder pain with difficulty performing overhead movements, and left wrist pain) and objective (diffuse tenderness of the entire left shoulder region, positive impingement sign of the left shoulder, tenderness to the left greater tuberosity, weak external rotation, forward elevation is 140 degrees, abduction is 130 degrees, internal rotation is 70 degrees, and external rotation is 80 degrees; left wrist and hand swelling and effusion with slight tenderness to the extensor carpi ulnaris tendon, and decreased left wrist range of motion) findings, imaging findings (MRI of the left wrist (8/9/13) report revealed tear in the triangular fibrocartilage complex, subchondral cyst in the capitate, scaphoid, and distal end of the ulna, and intra-articular fluid/effusion; MRI of the left shoulder (8/11/13) report revealed Type II acromion and lateral downward sloping of the distal acromion effacing the supraspinatus resulting in impingement), current diagnoses (left shoulder impingement syndrome and left wrist triangular fibrocartilage complex (TFCC) tear), and treatment to date (physical therapy of 7-8 months, wrist brace, steroid injections to left shoulder and left wrist with transient pain relief, and medications). Medical report identifies a request for left shoulder arthroscopic subacromial decompression with associated shoulder immobilizer/sling, post-operative cold therapy times 7 days, post-operative continuous passive motion times 21 days, post-operative physical therapy 3 times 8,

and pre-operative labs; and left wrist TFCC repair. Regarding associated surgical services: post-operative DME Purchase: shoulder immobilizer/sling, there is no documentation of open repair of large and massive rotator cuff tears. Regarding post-operative DME rental: Continuous Passive Motion times 21 days, there is no documentation of adhesive capsulitis. Regarding post-operative physical therapy 3 times 8, the proposed number of sessions exceeds guidelines (for an initial trial).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Left Shoulder Arthroscopic Subacromial Decompression: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Subacromial Decompression and Manipulation Under Anesthesia.

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area, positive impingement sign, and temporary relief of pain with anesthetic injection (diagnostic injection test); and imaging clinical findings: conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of left shoulder impingement syndrome. In addition, there is documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs (physical therapy) and failing conservative therapy for three months including cortisone injections. Furthermore, there is documentation of conservative care (physical therapy, steroid injection to left shoulder with transient pain relief, and medications), subjective findings (ongoing constant left shoulder pain, pain with overhead movements, tenderness over the greater tuberosity); objective clinical findings (weak abduction, tenderness over anterior acromial area, and positive impingement sign); and imaging clinical findings (MRI identifying impingement). Therefore, based on guidelines and a review of the evidence, the request for left shoulder arthroscopic subacromial decompression is medically necessary.

#### **Left Wrist Arthroscopic Decompression: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment 12th Edition (web), 2014, Forearm, Wrist & Hand, Triangular fibrocartilage complex (TFCC) reconstruction

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of wrist/hand complaints, red flags of a serious nature, failure to respond to conservative management (including splinting and injections), and clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention, as criteria necessary to support the medical necessity of triangular fibrocartilage complex repair. Within the medical information available for review, there is documentation of a diagnosis of left wrist triangular fibrocartilage complex (TFCC) tear. In addition, there is documentation of a request for left wrist TFCC repair. Furthermore, given documentation of subjective (left wrist pain) and objective (left wrist and hand swelling and effusion with slight tenderness to the extensor carpi ulnaris tendon, and decreased left wrist range of motion) findings, and imaging findings (MRI of the left wrist identifying tear in the triangular fibrocartilage complex), and failure of conservative treatment (wrist splint and cortisone injection), there is documentation of wrist/hand complaints, failure to respond to conservative management (including splinting and injections), and clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. Therefore, based on guidelines and a review of the evidence, the request for left wrist arthroscopic decompression is medically necessary.

**Post-Operative DME Purchase: Shoulder Immobilizer/Sling: Upheld**

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

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

**Decision rationale:** MTUS reference to ACOEM guidelines identifies that sling/splint for 7 days followed by gentle range of motion exercises, then progressive mobilization is indicated in the management of non-displaced radial head fractures. ODG identifies documentation of open repair of large and massive rotator cuff tears, as criteria necessary to support the medical necessity of shoulder immobilizer/sling. Within the medical information available for review, there is documentation of a diagnosis of left shoulder impingement syndrome. However, given documentation of an associated request for left shoulder arthroscopic subacromial decompression, there is no documentation of open repair of large and massive rotator cuff tears. Therefore, based on guidelines and a review of the evidence, the request for Associated Surgical Services: Post-Operative DME Purchase: Shoulder Immobilizer/Sling is not medically necessary.

**Post- Operative DME Rental: Continuous Passive Motion times 21 Days: Upheld**

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

**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 passive motion (CPM).

**Decision rationale:** MTUS does not address the issue. ODG identifies documentation of adhesive capsulitis, as criteria necessary to support the medical necessity of continuous passive motion for up to 20 days. ODG also notes that continuous passive motion is not recommended for shoulder rotator cuff problems, after shoulder surgery, or for nonsurgical treatment. Within the medical information available for review, there is documentation of diagnoses of left shoulder impingement syndrome and left wrist triangular fibrocartilage complex (TFCC) tear. In addition, there is documentation of an associated request for left shoulder subacromial decompression that has been certified/authorized. However, there is no documentation of adhesive capsulitis. In addition, the requested Continuous Passive Motion times 21 days exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for post-operative DME rental: Continuous Passive Motion times 21 days is not medically necessary.

**Post- Operative Physical Therapy 3 times 8: Upheld**

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

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

**Decision rationale:** MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS Postsurgical Treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. Within the medical information available for review, there is documentation of diagnoses of left shoulder impingement syndrome. In addition, there is documentation of an associated request for left shoulder subacromial decompression that has been certified/authorized. However, the proposed number of sessions exceeds guidelines (for an initial trial). Therefore, based on guidelines and a review of the evidence, the request for Post- Operative Physical Therapy 3 times 8 is not medically necessary.

**Associates Surgical Services: Pre- Operative Labs: CBC, PT, PTT, Urinalysis, CMP: Overturned**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative lab testing.

**Decision rationale:** MTUS does not address this issue. ODG identifies that preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. Within the medical information available for review, there is documentation of diagnoses of left shoulder impingement syndrome. In addition, given documentation of an associated request for left shoulder subacromial decompression that has been certified/authorized, there is documentation that preoperative testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management. Therefore, based on guidelines and a review of the evidence, the request for Associated Surgical Services: Pre-Operative Labs: CBC, PT, PTT, Urinalysis, CMP is medically necessary.