

<b>Case Number:</b>	CM15-0005772		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	06/17/2013
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/12/2015

### 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: New York  
 Certification(s)/Specialty: Neurological Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 62 year old female on June 17, 2013 reported a repetitive strain/sprain injury to the right shoulder. She described pulling small boxes out of a large box and then large box started to move and she reached out with her right arm and felt a sharp pain in her shoulder. Past surgical history included right shoulder operation in November 2002, left shoulder operation in 2006 and an injury settlement in 12/03. That evening in 2013 her shoulder began to swell and hurt. Her diagnoses have included right shoulder impingement syndrome with fibrosis and capsulitis and status postindustrial right shoulder injury. Treatment to date has included physical therapy, cortisone injection and pain medication. An ultrasound of the right shoulder was reported to reveal subacromial fibrosis, long-standing biceps tendon tear, degenerative changes of the supraspinatus and she was without a full-thickness rotator cuff tear. Currently, the injured worker complains of right shoulder pain which she rates a 7 on a 10-point scale. The injured worker reported moderate tenderness over the supraspinatus and greater tuberosity regions of the right shoulder and mild tenderness over the supraspinatus and greater tuberosity regions of the left shoulder. On December 24, 2014 Utilization Review non-certified a request for arthroscopic right shoulder decompression, possible distal clavicle resection and labral and rotator cuff debridement; pre-operative clearance to include a 2-night home sleep study to rule out sleep apnea; supervised post-operative rehabilitation therapy, three times per week for four weeks; home continuous passive motion device, initial 45 days; surgi-stem unit, initial 90 days and Coolcare cold therapy unit, noting there is no indication in the medical record of the amount of relief she received from the previous cortisone injection or the placement of the injection; no

indication on the ultrasound of rotator cuff pathology; no documentation of other possible pain pathology being investigated. In that the surgery was non-certified the associated requests were also non-certified. The California Medical Treatment Utilization Schedule ACOEM was cited. On January 12, 2015, the injured worker submitted an application for IMR for review of Arthroscopic right shoulder decompression, possible distal clavicle resection and labral and rotator cuff debridement; pre-operative clearance to include a 2-night home sleep study to rule out sleep apnea; supervised post-operative rehabilitation therapy , three times per week for four weeks; home continuous passive motion device, initial 45 days; surgi-stem unit, initial 90 days and Coolcare cold therapy unit.

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

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

**Arthroscopic right shoulder decompression, possible distal clavicle resection and labral and rotator cuff debridement: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder chapter-Surgery for impingement syndrome

**Decision rationale:** The ODG guidelines notes that arthroscopic acromioplasty provides no clinically important effects over a structured and supervised exercise program alone in terms of subjective outcome. The documentation does not show evidence of structured exercise treatment. Moreover, this worker has already had prior shoulder surgery. The guidelines note that arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. Thus the requested treatment: Arthroscopic right shoulder decompression, possible distal clavicle resection and labral and rotator cuff debridement is not medically necessary and appropriate.

**Associated surgical service: pre-operative clearance to include a 2 night home sleep study (polysomnogram) to rule out sleep apnea: 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.

**Associated surgical service: supervised post-operative rehabilitation therapy; three (3) times per week for four (4) weeks: 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.

**Associated Surgical service: home continuous passive motion (CPM) device; initial 45 days:**  
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.

**Associated Surgical service: SurgiStim unit; initial 90 days:** 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.

**Associated Surgical service: 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.