

<b>Case Number:</b>	CM15-0144542		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	09/01/2010
<b>Decision Date:</b>	09/15/2015	<b>UR Denial Date:</b>	07/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: Montana, Oregon, Idaho  
 Certification(s)/Specialty: Orthopedic 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:

The injured worker is a 58 year old male, who sustained an industrial injury on 9-01-2010. The injured worker was diagnosed as having left shoulderpain and dysfunction, left shoulder moderate to severe impingement, left shoulder SLAP tear, and left shoulder rotator cuff tendinosis with partial tear. Treatment to date has included diagnostics including magnetic resonance imaging of the left shoulder (10-18-2014), acupuncture, physical therapy, and medications. The Qualified Medical Evaluation (1-22-2015) noted a recommendation for arthroscopic left shoulder surgery for subacromial decompression, rotator cuff repair, and labrum repair versus debridement. Currently (6-10-2015), the injured worker complains of left greater than right shoulder pain and dysfunction. It particularly hurt at night, with reaching overhead, with lifting, and with going through range of motion. Physical exam of the left shoulder noted tenderness at the anterior acromial margin and AC joint, flexion 165 degrees, abduction 160 degrees, external rotation 80 degrees, and internal rotation 70 degrees. Speed's and impingement tests were positive. Sensorimotor exam was intact and pain was noted on resisted external rotation with the arm at his side. The treatment plan included left shoulder arthroscopy with subacromial decompression, debridement versus repair of rotator cuff, possible biceps tenotomy, and possible distal clavicle resection, polar care unit for 2 week rental, and sling with abduction pillow. His work status was total temporary disability. Current medication regimen was not noted. An initial acupuncture report, including treatment for the bilateral shoulders, was submitted for 6-15-2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Polar Care Unit, Left Shoulder, 2 wk 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: Shoulder - Continuous flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case the request exceeds the guidelines recommendation of 7 days. Therefore the request is not medically necessary.

### **Sling with Abduction Pillow, Left Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): table 9-6.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of abduction pillow. Per the ODG criteria, abduction pillow is recommended following open repair of large rotator cuff tears but not for arthroscopic repairs. In this case there is no indication for need for open rotator cuff repair and therefore the request is not medically necessary.

### **Rotator Cuff, Poss Biceps Tenotomy & Poss Distal Clavicle Resection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): table 9-6. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - Indications for surgery - Rotator cuff repair, Impingement syndrome.

**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.

**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 6/10/15 do not demonstrate 4 months of failure of activity modification. The physical exam from 6/10/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. The MRI report from 10/18/14 does not demonstrate full thickness rotator cuff tears. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case, the exam note from 6/10/15 do not demonstrate clinical exam findings to warrant distal clavicle resection. Therefore, the request is not medically necessary.

**Left Shoulder Arthroscopy with Debridement vs Repair, SAD: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): table 9-6. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - Diagnostic arthroscopy.

**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.

**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. An MRI of the left shoulder from 10/18/14 demonstrates acromioclavicular osteoarthritis, partial articular sided supraspinatus and infraspinatus tears, SLAP tear and long head of the biceps tenosynovitis. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 6/10/15. In addition night pain and weak or absent abduction must be present and is not documented in the clinical notes provided. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case, the exam note from 6/10/15 does not demonstrate a history of a positive response to subacromial injection or failed trial of physical therapy. Therefore, the requested surgical procedure is not medically necessary.