

<b>Case Number:</b>	CM15-0207762		
<b>Date Assigned:</b>	10/26/2015	<b>Date of Injury:</b>	01/15/2014
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2015

### 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: Minnesota, Florida

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 46 year old male, who sustained an industrial injury on 1-15-2014. The injured worker was being treated for status post right shoulder surgery. Treatment to date has included diagnostics, right shoulder surgery 3-26-2015, physical therapy, and medications. On 9-04-2015, the injured worker complains of persistent right shoulder pain and stiffness, pain in the right elbow, and numbness in the forearm. He reported increasing pain in his right shoulder since a fall onto his right side in 7-2015. Medication use included Motrin. He had a history of narcotic abuse and was reluctant to take narcotics. Exam noted the ability to forward elevate the right shoulder 145 degrees, abduction 140 degrees, external rotation was 'limited', and internal rotation was 45 degrees. There was tenderness over the anterior aspect of the shoulder and ongoing tenderness over the antecubital region and proximal right forearm. Magnetic resonance imaging of the right shoulder (10-01-2015) showed evidence of subacromial decompression and debridement of the cuff, minor inflammation of the subacromial bursa, micrometallic artifact limiting visualization of discrete bursal margin, artifact limits evaluation of the superior cuff, no full-thickness tear gap present, moderate insertional subscapularis tendinosis without disruption of fibers, the intrascapular portion of the biceps was deficient and the intertubercular groove was empty along the humeral neck, suture anchors in glenoid from prior SLAP repair, linear interstitial cleavage tear in the posterosuperior labrum behind the more posterior anchor on axial 11, labrum partially detached from 10 to 11 o'clock position, and significant inflammation and thickening of the capsule at the axillary pouch. His work status was total temporary disability. The treatment plan included right shoulder arthroscopy, rotator cuff debridement, SLAP repair or debridement, lysis of adhesions, ice machine, deluxe arm sling, and post-operative physical therapy x12. On 10-12-2015 Utilization Review modified the request to right shoulder

arthroscopy, SLAP repair or debridement, lysis of adhesions, ice machine rental to 7 days, deluxe arm sling, and physical therapy x12.

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

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

**Right shoulder arthroscopy, rotator cuff debridement, SLAP repair or debridement, lysis of adhesions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute and Chronic) (updated 09/08/15).

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** Per available documentation, the surgical request was for a right shoulder arthroscopy, rotator cuff debridement, SLAP repair or debridement and lysis of adhesions. This was modified by utilization review with non-certification of the rotator cuff debridement. The remaining requests were certified. The disputed request pertains to debridement of the rotator cuff. California MTUS guidelines indicates surgery for partial-thickness or smaller full-thickness tears for cases failing conservative therapy for 3 months. The preferred procedure is usually arthroscopic decompression in these cases. In this case, the MRIs scan does not show a recurrent rotator cuff tear. As such, the request for rotator cuff debridement is not medically necessary. The remaining surgical requests have been certified by utilization review.

**Associated surgical service: ice machine:** 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 (Acute and Chronic) (updated 09/08/15).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: Continuous flow cryotherapy.

**Decision rationale:** With regard to the request for an ice machine, ODG guidelines recommend continuous-flow cryotherapy as an option after surgery for 7 days. It reduces pain, inflammation, swelling, and the need for narcotics after surgery. Use beyond 7 days is not recommended. The request as stated is for an ice machine but does not indicate if it is for a rental or purchase. As such, the utilization review modification is appropriate and the medical necessity of the request has not been substantiated.