

<b>Case Number:</b>	CM15-0025075		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	07/06/2011
<b>Decision Date:</b>	04/10/2015	<b>UR Denial Date:</b>	01/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2015

### 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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 41-year-old male, with a reported date of injury of 07/06/2011. The diagnoses include right impingement syndrome, right medial/lateral epicondylitis, distal biceps tendinitis, right cubital tunnel syndrome, possible radial nerve neuropathy, and right carpal tunnel syndrome. Investigations have included an MR Arthrogram on 11/26/2014, which showed moderate acromioclavicular osteoarthritis, no cartilaginous defect, no rotator cuff tear, inferior labral tear and intact bicep tendon. The 12/23/2014 EMG of the neck/upper extremity was reported as normal, the IW completed PT and activity modification. The 9/22/2014 X-Ray of the left knee showed medial compartment narrowing, the medications listed are Norco and Ibuprofen. The UDS reported dated 9/12/2014 and 1/23/2015 was noted to be inconsistent with the absence of prescribed hydrocodone. The progress report dated 01/15/2015 was handwritten and partially illegible. The report indicates that the injured worker complained of worsening right shoulder pain. There was increased pain after a recent Arthrogram. The objective findings included tenderness to palpation of the right ulnar nerve, tenderness to palpation of the right carpal tunnel, decreased range of motion of the right shoulder, and positive right shoulder impingement. The Neer's crossover and Hawkins tests are positive. The treating physician requested right shoulder arthroscopy, subacromial decompression, Mumford, possible biceps tendinosis/labral repair, postoperative physical therapy three times a week for four weeks, cold therapy for seven days, an immobilizer, and purchase of a replacement transcutaneous electrical nerve stimulation (TENS) unit. On 01/22/2015, Utilization Review (UR) denied the request for right shoulder arthroscopy, subacromial decompression, Mumford, possible biceps

tendinosis/labral repair, postoperative physical therapy three times a week for four weeks, cold therapy for seven days, an immobilizer, and purchase of a replacement transcutaneous electrical nerve stimulation (TENS) unit. The UR physician noted that there was no documentation of acromioclavicular joint degeneration on imaging, no documentation of conservative treatment, and no involvement of the biceps tendon which indicates there was no need for a labral repair and biceps tendinosis. Since the surgical intervention was not certified, the associated requests are also not medically necessary. The MTUS ACOEM Guidelines, the non-MTUS Official Disability, MTUS Postsurgical Treatment Guidelines, and MTUS Chronic Pain Guidelines were cited.

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

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

#### **Right Shoulder Arthroscopy Subacromial Decompression: Upheld**

**Claims Administrator 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.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Shoulder.

**Decision rationale:** The CA MTUS, ACOEM and ODG guidelines recommend that surgical procedures on the shoulder joint can be utilized in the treatment of severe joint arthritis pain when conservative treatments with medications, PT and minimally invasive injection treatment have failed. The records did not show subjective, objective and radiological findings consistent with the diagnosis of a severe right shoulder condition. There was no radiological documentation of significant tendon tear, rotator cuff tear or severe joint arthritis. There is no documentation of failure of minimally invasive injection treatments. There is questionable compliance with medication management because of inconsistent UDS reports. The records did not show that the patient failed treatment with steroid injection for the right shoulder acromioclavicular joint osteoarthritis pain. The criteria for arthroscopic right shoulder subacromium decompression were not met.

#### **Mumford Poss Biceps Tenodesis/ Labral Repair: Upheld**

**Claims Administrator 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.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Shoulder.

**Decision rationale:** The CA MTUS, ACOEM and ODG guidelines recommend that surgical procedures on the shoulder joint can be utilized in the treatment of severe joint arthritis pain when conservative treatments with medications, PT and minimally invasive injection treatment have failed. The records did not show subjective, objective and radiological findings consistent with the diagnosis of a severe right shoulder condition. There was no radiological documentation of significant tendon tear, rotator cuff tear or severe joint arthritis. There is no documentation of failure of minimally invasive injection treatments. There is questionable compliance with medication management because of inconsistent UDS reports. The records did show that the bicep tendon did not have any abnormality. The patient did not fail treatment with steroid injection for the right shoulder joint osteoarthritis pain. The criteria for Mumford procedure Bicep tendinosis/labral repair were not met.

**Post op Physical Therapy 3x4 Weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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) Pain Chapter Post-op PT.

**Decision rationale:** The CA MTUS, ACOEM and ODG guidelines recommend that surgical procedures on the shoulder joint can be utilized in the treatment of severe joint arthritis pain when conservative treatments with medications, PT and minimally invasive injection treatment have failed. The records did not show subjective, objective and radiological findings consistent with the diagnosis of a severe right shoulder condition. There was no radiological documentation of significant tendon tear, rotator cuff tear or severe joint arthritis. There is no documentation of failure of minimally invasive injection treatments. There is questionable compliance with medication management because of inconsistent UDS reports. The records did not show that the patient failed treatment with steroid injection for the right shoulder acromioclavicular joint osteoarthritis pain. The criteria for post operative physical therapy 3-4 weeks were not met because the criteria for surgery were not met.

**Cold Therapy x7 Days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cryotherapies.

**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) Pain Chapter Cold Therapy.

**Decision rationale:** The CA MTUS, ACOEM and ODG guidelines recommend that surgical procedures on the shoulder joint can be utilized in the treatment of severe joint arthritis pain when conservative treatments with medications, PT and minimally invasive injection treatment have failed. The records did not show subjective, objective and radiological findings consistent with the diagnosis of a severe right shoulder condition. There was no radiological documentation

of significant tendon tear, rotator cuff tear or severe joint arthritis. There is no documentation of failure of minimally invasive injection treatments. There is questionable compliance with medication management because of inconsistent UDS reports. The records did not show that the patient failed treatment with steroid injection for the right shoulder acromioclavicular joint osteoarthritis pain. The criteria for post operative Cold Therapy for 1 week were not met because the criteria for surgery were not met.

**Replacement TENS Unit Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 113-117, 121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Electrical Stimulation Treatments.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that TENS unit can be utilized for the treatment of musculoskeletal pain. The use of TENS unit can result in pain relief, reduction in medication utilization and functional restoration. The records did not show any documentation of beneficial effects from prior utilization of the TENS unit. There was no detailed on the duration of TENS's unit use or why a replacement unit is required. The criteria for the purchase of a replacement TENS unit was not met.

**Immobilizer:** 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.

**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) Pain Chapter Post Operative Immobilization.

**Decision rationale:** The CA MTUS, ACOEM and ODG guidelines recommend that surgical procedures on the shoulder joint can be utilized in the treatment of severe joint arthritis pain when conservative treatments with medications, PT and minimally invasive injection treatment have failed. The records did not show subjective, objective and radiological findings consistent with the diagnosis of a severe right shoulder condition. There was no radiological documentation of significant tendon tear, rotator cuff tear or severe joint arthritis. There is no documentation of failure of minimally invasive injection treatments. There is questionable compliance with medication management because of inconsistent UDS reports. The records did not show that the patient failed treatment with steroid injection for the right shoulder acromioclavicular joint osteoarthritis pain. The criteria for post operative Immobilization was not met because the criteria for surgery were not met.