

<b>Case Number:</b>	CM15-0032320		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	02/08/2014
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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: California  
 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 36 year old male, who sustained an industrial injury on February 8, 2014. He has reported he reached overhead and lifted an empty bread tray from a rack and felt a pop in the right shoulder that was followed by pain, he had X-rays of the right shoulder that were normal. The diagnoses have included acromioclavicular joint arthritis and right shoulder superior labral tear. Treatment to date has included physical therapy, medication and a Magnetic resonance imaging in July 2014 which revealed a labrum tear and referred to orthopedic surgeon. Currently, the injured worker complains of right shoulder pain. In a progress note dated January 19, 2015, the treating provider reports examination of the right shoulder reveals tenderness with palpation which localizes to the acromioclavicular joint and mild tenderness of the anterior shoulder, decreased range of motion mild pain with Neer impingement test and mild pain with cross arm adduction test, positive O'Brien's test. On January 28, 2015 Utilization Review non-certified right shoulder arthroscopy-debridement acromioplasty/decompression, distal clavicle excision, possible biceps tenodesis, post-operative physical therapy 2x6, DME ultra sling and cold therapy, the Utilization Review does not note what 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 Arthroscopic -debridement, acromioplasty/ Decompression and Distal Clavicle Excision, possible biceps tenodesis: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Section.

**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. 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 01/19/15. In addition night pain and weak or absent abduction must be present. 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 01/19/15 does not demonstrate evidence satisfying the above criteria. Therefore the determination is for non-certification.

**Post op Physical Therapy 2x6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** CA MTUS/Chronic Pain Medical Treatment Guidelines, Physical Medicine, page 98-99 recommend the following for non-surgical musculoskeletal conditions, Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. As the requested physical therapy exceeds the recommendation, the determination is for non-certification. As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**DME Ultra Sling: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**Decision rationale:** According to the California MTUS guidelines, Shoulder complaints Chapter 9 pages 212-214, it is recommended to use a brief use of the sling for severe shoulder pain (1-2 days) with pendulum exercises to prevent stiffness and cases of rotator cuff conditions, and prolonged use of the sling only for symptom control is not supported. In this case the use of a shoulder sling would be contraindicated following right shoulder arthroscopy to prevent adhesive capsulitis. The request for a sling is therefore not medically necessary and appropriate. As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Section.

**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 determination is for non-certification. As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.