

<b>Case Number:</b>	CM15-0036142		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	01/06/2014
<b>Decision Date:</b>	04/09/2015	<b>UR Denial Date:</b>	02/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2015

### 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: Illinois, California, Texas  
 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 43-year-old female who sustained a work related injury on 1/6/14. Injury to her shoulder and neck occurred while loading cargo boxes. She was diagnosed with cervical disc displacement and radiculopathy, and underwent C5/6 anterior cervical discectomy and fusion on 5/1/14. She subsequently underwent an arthroscopic labral debridement and subacromial decompression on 8/7/14. She continued to report severe neck, upper back and right shoulder pain with right hand numbness. The 1/16/15 right shoulder MR arthrogram impression documented mild tendinopathy of the supraspinatus tendon, with no evidence of any full thickness or rotator cuff tears. There was a type II acromion and no appreciable labral injury. The 1/22/15 orthopedic report documented right shoulder forward flexion 145 degrees, and external rotation 60 degrees at 90 degrees abduction, both with severe pain. The remaining of the right shoulder exam was difficult to perform secondary to pain. The diagnosis included right shoulder adhesive capsulitis with severe intraarticular pain type II acromion, and significant neck pain with right upper extremity C5 and C7 radiculopathy status post C5 and C6 fusion. The injured worker had failed to improve despite an extended period of time since her last surgery, conservative treatment, and anti-inflammatory medications. The treatment plan recommended diagnostic right shoulder arthroscopy with possible rotator cuff repair, possible labral repair, subacromial decompression, and Mumford procedure. On 2/20/15, a request for a right shoulder arthroscopy with possible right rotator cuff and SLAP repair, subacromial decompression and Mumford; a request for a cryotherapy unit-7 day rental; a request for post-operative physical therapy twice a week for six weeks for a total of 12 sessions; and a request for medical clearance

for an electrocardiogram (EKG), chest x ray, lab work and pulmonary function studies was non-certified by utilization review, noting the California Medical Treatment Utilization Schedule Guidelines. The rationale for non-certification noted the treating physician reported the patient had a frozen shoulder and there was no evidence of corticosteroid injection and a failed conservative treatment. Records indicated that the patient had 2 post-op physical therapy visits.

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

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

**Arthroscopy of right rotator cuff and SLAP repair, subacromial decompression and mumford:** Upheld

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

**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) Shoulder: Surgery for rotator cuff repair; Surgery for impingement syndrome; Surgery for SLAP lesions; Partial claviclectomy.

**Decision rationale:** The California MTUS guidelines provide a general recommendation for impingement and rotator cuff repair surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines (ODG) provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Conventional x-rays, AP, true lateral or axillary view and MRI, ultrasound, or arthrogram showing positive evidence of impingement are required. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. Guideline criteria have not been met. This patient presents with significant right shoulder pain with motion following right shoulder surgery in August 2014. Range of motion is documented as 145 degrees flexion and 60 degrees external rotation. There is no clinical exam evidence of impingement, weakness, or specific rotator cuff or acromial tenderness. A corticosteroid injection is not evidenced. There is no imaging evidence of a rotator cuff or labral tear, or specific evidence of residual impingement. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

**Cyro unit 7 day rental:** 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 (ODG) Shoulder: Continuous-flow cryotherapy.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Postoperative physical therapy 2 times a week for 6 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.

**Medical clearance for electrocardiogram (EKG) chest xray lab and Pulmonary Function Testing (PFT):** 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.