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| <b>Case Number:</b>   | CM15-0045493 |                              |            |
| <b>Date Assigned:</b> | 03/17/2015   | <b>Date of Injury:</b>       | 10/24/2011 |
| <b>Decision Date:</b> | 05/11/2015   | <b>UR Denial Date:</b>       | 02/20/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/10/2015 |

### 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 59-year-old female who reported an injury on 10/24/2011. The mechanism of injury was cumulative trauma as a result of her job duties and physical requirements. Her diagnoses included sprain of wrist NOS. Her past treatments have included physical therapy, anti-inflammatories, home exercise program, steroid injections. Diagnostic studies included a right shoulder MRI on 12/17/2014 that indicated acromioclavicular osteoarthritis, subchondral cyst formation in the humeral head, bicipital tenosynovitis, supraspinatus tendonitis, and infraspinatus tendonitis. Her surgical history was noncontributory. The injured worker had complaints of frequent, severe right shoulder burning pain, stabbing right elbow pain, and constant severe right wrist burning pain. She rated these regions at an 8/10. On physical exam, it was noted the injured worker had reduced right shoulder range of motion with tenderness to palpation throughout the shoulder region and a positive impingement test. The right elbow and right wrist ranges of motion were reduced and associated with tenderness to palpation. Her medications were not included. Her treatment plan included requesting an MRI of the right shoulder, recommended to proceed with right shoulder arthroscopy, subacromial decompression, debridement versus repair of the rotator cuff as indicated at the time of surgery, possible distal clavicle resection, and possible biceps tenotomy. A rationale was not included. A Request for Authorization form is signed and dated 12/03/2014 in the medical record.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 right shoulder arthroscopy, subacromial decompression, debridement versus repair of the rotator cuff, possible distal clavicle resection and possible biceps tenotomy: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211 and 214. Decision based on Non-MTUS Citation Surgery general information and ground rules, California official medical fee schedule, 1999 edition, pages 92-93.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome.

**Decision rationale:** The request for 1 right shoulder arthroscopy, subacromial decompression, debridement versus repair of the rotator cuff, possible distal clavicle resection and possible biceps tenotomy is not medically necessary. The California MTUS guidelines state the criteria for acromioplasty includes conservative care, pain with active arc motion and pain at night. Weak or absent abduction, tenderness over rotator cuff and positive impingement sign and temporary relief of pain with anesthetic injection. Imaging findings that include positive evidence of impingement. As the criteria were met, the surgery is medically necessary.

**1 preoperative clearance: Complete metabolic panel, PT, PTT, CBC, electrolytes, BUN, Creatine, Glucose, EKG, and chest x-rays: Overturned**

**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) Low Back, Preoperative lab testing.

**Decision rationale:** The Official Disability Guidelines state the decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach. Therefore, the request for complete metabolic panel, PT, PTT, CBC, electrolytes, BUN, Creatinine, Glucose, EKG, and Chest X-Rays is medically necessary.

**6 post op physical therapy: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** The California MTUS Post-Surgical Treatment Guidelines state post-surgical treatment, arthroscopic: 24 visits. Therefore, the request for 6 post op physical therapy is medically necessary.

**1 right shoulder sling abduction pillow:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

**Decision rationale:** The Official Disability Guidelines state the request for shoulder sling abduction pillow is recommended as an option following open repair of large and massive rotator cuff tears. The request for surgery was for arthroscopic shoulder surgery. However, as the patient has a full thickness tear, an abduction pillow would be indicated in this clinical situation to allow for stabilization of the joint post-surgically and protects the tendons from re-tearing. Therefore, the request for shoulder sling abduction pillow is medically necessary.

**1 polar care unit rental for 2 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

**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:** The Official Disability Guidelines state the continuous-flow cryotherapy unit is recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use. The request for 14 days. Therefore, the request for polar care unit rental for 2 weeks is not medically necessary.