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| <b>Case Number:</b>   | CM15-0085159 |                              |            |
| <b>Date Assigned:</b> | 06/08/2015   | <b>Date of Injury:</b>       | 10/01/2012 |
| <b>Decision Date:</b> | 07/10/2015   | <b>UR Denial Date:</b>       | 04/28/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/04/2015 |

### 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 36-year-old female who sustained an industrial injury on 10/1/12. Injury occurred when she lifted a large overhead cabinet door and it fell off its hinges. She caught and held to door to avoid hitting a co-worker, with onset of neck and right shoulder pain. Past medical history was reported negative. The 8/2/14 right shoulder MRI conclusion documented tendinosis and peritendinitis of the supraspinatus with no rotator cuff tear identified. There was tenosynovitis of the biceps tendon. There was arthropathy of the acromioclavicular (AC) joint with os acromiale. The 3/30/15 treating physician report cited grade 5/10 right shoulder pain. She had failed all attempts at aggressive conservative management including physical therapy, massage, corticosteroid injection, various anti-inflammatory and analgesic medications, and the passage of time. Right shoulder range of motion was reported flexion 140, extension 40, abduction 140, adduction 40, external rotation 90, and internal rotation 60 degrees with pain. There was severe tenderness over the supraspinatus tendon, moderate tenderness over the greater tuberosity and AC joint, and mild tenderness over the biceps tendon. There was global 4/5 right shoulder weakness. AC joint compression and impingement tests were positive. Imaging showed tendinosis of the supraspinatus tend with arthropathy of AC joint but no rotator cuff or labral tear noted. The diagnosis was right shoulder impingement syndrome. The treatment plan recommended right shoulder arthroscopic decompression, distal clavicle resection and rotator cuff and/or labral debridement as indicated. Authorization was requested for arthroscopic right shoulder decompression, distal clavicle resection, and rotator cuff and/or labral debridement, standard pre-operative medical clearance, a Surgi-Stim unit x 90 days, continuous passive

motion (CPM) device for an initial period of 45 days, and a Coolcare cold therapy unit. The 4/28/15 utilization review modified the request for arthroscopic right shoulder decompression, distal clavicle resection, and rotator cuff and/or labral debridement to arthroscopic right shoulder decompression and distal clavicle resection as there was no imaging evidence of a rotator cuff or labral tear. The request for standard pre-operative medical clearance with labs to include CBC and BMP was modified to include CBC and BMP only based on patient age and intermediate risk of the associated surgery. The request for a Surgi-Stim unit was non-certified as there was no evidence of the need for multiple pain modalities for post-operative pain management. The request for a CPM device was non-certified based on an absence of guideline support and limited evidence of extraneous circumstances that necessitate shoulder CPM. The request for a Coolcare cold therapy unit was modified to 7-day rental of a standard cold therapy unit consistent with the Official Disability Guidelines.

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

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

#### **Arthroscopic right shoulder decompression, distal clavicle resection, and rotator cuff and/or labral debridement: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, Table 9-3. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation (ODG-TWC), Shoulder Procedure Summary (online version), Indications for Surgery Acromioplasty and Rotator cuff repair and DeLee and Drez's Orthopaedic Sports Medicine, 2nd ed., Saunders, And Imprint of Elsevier, page 925-926.

**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 impingement syndrome; Surgery for rotator cuff repair; Surgery for SLAP repair; Partial claviclectomy.

**Decision rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines provide indications for impingement syndrome that include 3 to 6 months of conservative treatment, 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, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. 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 degenerative joint disease. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. Guidelines state definitive diagnosis of SLAP lesions is diagnostic

arthroscopy. Guideline criteria have been met. This injured worker presents with persistent right shoulder pain and functional limitations. Clinical exam findings are consistent with imaging evidence of impingement, and plausible rotator cuff pathology. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Guidelines indicate that definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Given the clinical exam findings consistent with potential rotator cuff tear and possible labral pathology, surgery at these levels may be indicated. Therefore, this request is medically necessary.

**Standard pre-operative medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation (ODG-TWC), preoperative testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. The 4/28/15 utilization review modified this request to allow for pre-operative labs: complete blood count and basic metabolic panel. The rationale for additional pre-operative medical clearance is not documented in the available records to establish medical necessity in the absence of positive past medical history and given the injured worker's age. Therefore, this request is not medically necessary.

**Associated surgical service: Surgi-stim unit x 90days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not

been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Therefore, this request is not medically necessary.

**Associated surgical service: Continuous passive motion (CPM) device, initial period x45 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation (ODG-TWC), Shoulder Procedure Summary (Online version), Continuous passive motion (CPM).

**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 passive motion (CPM).

**Decision rationale:** The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is not recommended for shoulder rotator cuff problems or after shoulder surgery, except in cases of adhesive capsulitis. Guideline criteria have not been met. There is no current evidence that this patient has adhesive capsulitis. Prophylactic use of continuous passive motion in shoulder surgeries is not consistent with guidelines. Therefore, this request is not medically necessary.

**Associated surgical service: Coolcare cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation (ODG-TWC), Shoulder Procedure Summary (online version), Continuous-flow cryotherapy.

**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 California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively. The 4/28/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the records reviewed to support the medical necessity of a cold therapy unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

