

<b>Case Number:</b>	CM15-0086050		
<b>Date Assigned:</b>	05/08/2015	<b>Date of Injury:</b>	10/07/2014
<b>Decision Date:</b>	06/09/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2015

### 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, Indiana, Oregon  
 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 64 year old female, who sustained an industrial injury on October 7, 2014 while working as a clerical resident manager. The mechanism of injury was a trip and fall in which the injured worker sustained injuries to the neck, chest wall, low back, shoulders, arms, hands and right ankle. The diagnoses have included lumbar sprain/strain, shoulder /upper arm sprain/strain, right wrist sprain/strain, right ankle sprain/strain, acute upper back sprain/strain, carpal tunnel syndrome, right shoulder full thickness rotator cuff tear with acromioclavicular joint arthritis and contusion of the breast. Treatment to date has included medications, radiological studies, electrodiagnostic studies, physical therapy, a cortisone injection and activity modification. Current documentation dated April 6, 2015 notes that the injured worker reported persistent right shoulder pain which radiated to the posterior trapezius muscles and down the right arm. Examination of the left shoulder revealed tenderness over the acromioclavicular joint and a decreased range of motion. The treating physician's plan of care included a request for a right shoulder arthroscopy, possible subacromial decompression, possible distal clavicle resection arthroplasty, possible labral repair, possible bicep tenodesis and possible rotator cuff repair and a fourteen day rental of a cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy, Possible Subacromial Decompression, Possible Distal Clavicle Resection Arthroplasty, Possible Labral Repair, Possible Bicep Tenodesis, and Possible Rotator Cuff Repair: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** 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. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. In this case the MRI from 2/24/15 does not show a labral tear or biceps tendon tear to warrant surgery within the guidelines. Therefore determination is not medically necessary.

**Associated Surgical Service: 14 Day Rental of A Cold Therapy Unit: 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. 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 guideline duration and is not medically necessary.