

<b>Case Number:</b>	CM13-0033026		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	03/27/2010
<b>Decision Date:</b>	03/07/2014	<b>UR Denial Date:</b>	09/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 48 year old female who reported injury on 05/23/2012. The mechanism of injury was not provided. The patient was noted to have an MRI on 08/04/2012 which revealed the patient had minimal joint effusion, mild capsular hypertrophy, and mild to moderate fluid surrounding the coracobrachialis tendon. The patient was noted to be receiving greater function in activity with the patient's medications. The patient was noted to be treated with medications, injections, physical therapy, a home exercise program, and a TENS unit. The patient's physical examination revealed the patient had right shoulder limited range of motion and markedly positive impingement signs per documentation. The diagnosis was noted to include persistent impingement syndrome of the right shoulder failing conservative management. The request was made for a right shoulder arthroscopy subacromial decompression, postoperative sling, cold unit 7 days rental, and postoperative physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy Subacromial Decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**Decision rationale:** ACOEM Guidelines indicate that a referral for surgical consult may be appropriate for patients who have red flag conditions, activity limitations for more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion plus clear, clinical and imaging evidence of a lesion that has been shown to benefit in both the long and short-term from surgical repair. It further indicates that a subacromial decompression is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care including cortisone injections should be carried out for at least 3 to 6 months before considering surgery. The patient's physical examination revealed the patient had right shoulder limited range of motion and markedly positive impingement signs per documentation. The clinical documentation submitted for review indicated the patient had an MRI which revealed no rotator cuff or impingement findings. The patient was noted to have tenderness at the right shoulder anterior aspect and at release. The right shoulder abduction was noted to be 80 degrees and forward flexion was noted to be 90 degrees. The patient was noted to have medications that facilitated greater function and greater activity level. The ADLs were noted to be maintained with medication which included grooming, grocery shopping, and simple essential household duties. There was a lack of documentation indicating the patient had activity limitations and the patient's symptoms were noted to be well controlled with medications. There was a lack of documentation of an objective physical examination to support that the patient had objective signs of impingement. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for right shoulder arthroscopy subacromial decompression is not medically necessary.

**Post -OP Sling:** 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), Shoulder Chapter.

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

**Decision rationale:** Official Disability Guidelines recommend a postoperative abduction pillow sling for an open repair of large and massive rotator cuff tears. There was a lack of documentation supporting the necessity for the requested subacromial decompression. Given the above, the request for post op sling is not medically necessary.

**Cold Unit 7 days 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 Chapter, Continuous-flow cryotherapy.

**Decision rationale:** Official Disability Guidelines indicate that continuous flow cryotherapy is recommended as an option after surgery for up to 7 days including home use. There was a lack of documentation supporting the necessity for the requested subacromial decompression. As the request for the surgery was not medically necessary, the requested for cold unit 7 days rental is not medically necessary.

**Post -OP Physical Therapy three times a week for four weeks to the Right Shoulder:**

Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10 and 27.

**Decision rationale:** California MTUS Postsurgical Treatment Guidelines indicate the treatment for subacromial decompression surgery is 24 visits. However, the initial therapy should be one half the recommended visits, which would be 12 visits. There was a lack of documentation supporting the necessity for the requested subacromial decompression. As the request for surgery was not medically necessary, the request for post op physical therapy three times a week for four weeks to the right shoulder is not medically necessary.