

<b>Case Number:</b>	CM14-0140701		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	08/13/2011
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/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 claimant is a 48-year-old female who injured her left shoulder at work on August 13, 2011 while lifting a heavy piece of luggage. The clinical records provided for review included the report of a left shoulder MRI dated May 1, 2014, that identified supraspinatus and infraspinatus tendonopathy with partial thickness tearing, no full thickness rotator cuff pathology, a down sloping acromion and no other clinical findings. The report of clinical assessment on July 21, 2014 noted continued complaints of pain in the left shoulder; there was no documentation of physical examination findings. The claimant was diagnosed with left shoulder impingement syndrome with documentation that conservative care had included medications, physical therapy and a prior corticosteroid injection. The recommendation was made for arthroscopy, decompression and rotator cuff repair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Preoperative Medical Clearance with laboratory tests: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental

Medicine (ACOEM), 2nd Edition, (2004); CA MTUS ACOEM OMPG (Second Edition, 2004), Chapter 7 Independent Medical Examinations and Consultations, page 127

**Decision rationale:** California ACOEM Guidelines would not support the role of preoperative medical clearance or laboratory testing. The role of operative intervention in this individual's course of care has not been established. This would negate the need for preoperative medical clearance or preoperative laboratory assessment. The request is not medically necessary.

**14 Day rental of Vascutherm Unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Knee and Leg Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, 555-556..

**Decision rationale:** The request for left shoulder arthroscopic acromioplasty and rotator cuff repair is not recommended as medically necessary. Therefore, the request for postoperative use of a Vascutherm (cryotherapy) device is not medically necessary.

**1 Left shoulder Arthroscopic Acromioplasty and Rotator Cuff repair: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Chapter 9 Shoulder Complaints (ODG) Official Disability Guidelines Indication for surgery -rotator cuff repair(ODG) Official Disability Guidelines Indication for surgery - Acromioplasty

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

**Decision rationale:** The California ACOEM Guidelines do not support the request for left shoulder arthroscopic acromioplasty and rotator cuff repair. ACOEM Guidelines recommend that conservative care, including cortisone injections, be carried out for at least three to six months before considering surgery for impingement syndrome. ACOEM also recommends that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation. The medical records provide for review do not identify full thickness rotator cuff pathology or provide any clinical records that show evidence of positive physical examination findings. While it is noted that the claimant has failed conservative care, the lack of documentation of physical examination findings and absence of full thickness rotator cuff pathology fails to support the request for the proposed surgery. The request is not medically necessary.

**12 Post Operative physical therapy sessions: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The request for left shoulder arthroscopic acromioplasty and rotator cuff repair is not recommended as medically necessary. Therefore, the request for twelve sessions of postoperative physical therapy is not medically necessary.