

<b>Case Number:</b>	CM14-0085867		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	02/03/1997
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	05/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 patient is a 55-year-old man who was injured in a work related accident on February 03, 1997. The medical records provided for review document continued complaints of right shoulder pain. The report of a right shoulder MRI dated April 08, 2014 identified partial thickness tearing and fraying of the rotator cuff tendons with no full thickness pathology, degenerative labral fraying, and degenerative changes of the glenohumeral joint. Follow up clinical assessment on April 28, 2014 noted continued complaints of shoulder pain and that the claimant had failed conservative treatment of home exercises, physical therapy, medications and a corticosteroid injection in August 2012. Physical examination revealed restricted range of motion for flexion and extension, 4-/5 strength in the supraspinatus and positive impingement signs. The recommendation was made for surgical arthroscopy, rotator cuff repair versus debridement, decompression, labral and distal clavicle procedures. The records document that the claimant had been certified for surgery in January 2013 for right shoulder arthroscopy labral repair, subacromial decompression, distal clavicle excision and rotator cuff debridement. The claimant had put surgery on hold for year due to personal issues. With updated MRI findings, the operative procedures were once again recommended. As stated surgery had previously been certified in 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy (rotator cuff repair and debridement, subacromial decompression, labral repair and Mumford Procedure):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp; 18th. Edition; 2013 Updates; Shoulder Chapter: Mumford Procedure; Indications for Surgery - Partial claviclectomy

**Decision rationale:** Based on California ACOEM Practice Guidelines, the request for right shoulder arthroscopy, rotator cuff repair/debridement, subacromial decompression, labral repair and Mumford Procedure is recommended as medically necessary. This individual had previously been certified for the above surgical process in January 2013 which he elected to delay due to personal issues. His updated MRI scan supports the role of operative intervention. He continues to be symptomatic with weakness. Surgical procedure as outlined would be supported as medically necessary.

**Surgical Assistance (two Orthopaedic Surgeons):** 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 Milliman Care Guidelines, 18th edition: Assistant Surgeon Guidelines: Arthroscopy, shoulder, surgical; with rotator cuff repair.

**Decision rationale:** The California MTUS and the ACOEM Practice Guidelines do not provide criteria relevant to this request. Based on the Milliman Care Guidelines, the request for two orthopedic surgeons for surgical assistance in an arthroscopic procedure of the shoulder is not supported. Therefore, the request is not medically necessary.

**Y- Pulse unit (for purchase):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) / Transcutaneous electrotherapy Page(s): 114-.

**Decision rationale:** Based on California MTUS Chronic Pain Medical Treatment Guidelines, the request for a y-pulse device would not be indicated. This form of TENS unit would not be indicated as there is no specific timeframe for its use. It states that it is for purchase. The Chronic Pain Guidelines would support the role of a TENS unit for up to 30 days in the post-operative setting but not beyond. Therefore, the request is not medically necessary.

**Multi-Stim Unit (with supplies, 3-month rental): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118, 120, 121.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines would not support the use of a multi-stemmed device. Typically multi-stim devices are a combination of interferential stimulation and NMES stimulation. NMES stimulators are only recommended as a treatment option following stroke. There is no current indication for its use in the post operative or peri-operative setting. The role of this multi-stimulator would not be indicated as medically necessary.

**Continuous Passive Motion (CPM) Unit (6- week 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) Treatment in Workers Comp, 18th Edition, 2013 Updates: Shoulder Procedure - Continuous passive motion (CPM)

**Decision rationale:** The California MTUS and ACOEM Practice Guidelines do not provide criteria relevant to this request. When looking at the Official Disability Guidelines, the request for a CPM device is not recommended as medically necessary. The Official Disability Guidelines recommend that a CPM can be utilized following manipulation procedures but there is no clinical indication for its use following shoulder arthroscopy, decompression, or rotator cuff/labral surgery. Therefore, the request is not medically necessary.

**Pain Pump (for 4 days): 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) Treatment in Workers Comp, 18th Edition, 2013 Updates: Shoulder Procedure - Postoperative pain pump.

**Decision rationale:** The California MTUS and ACOEM Practice Guidelines do not provide criteria relevant to this request. Based on the Official Disability Guidelines, a pain pump following surgery would not be indicated. The Official Disability Guidelines do not recommend the use of pain pumps following a surgical process, as there is no indication of long-term benefit

or efficacy with randomized clinical trials. The postoperative use of this device would not be supported following shoulder arthroscopy. Therefore, the request is not medically necessary.

**Ultra Sling (for purchase): 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) Treatment in Workers Comp, 18th Edition, 2013 Updates: shoulder procedure

**Decision rationale:** The California MTUS and ACOEM Practice Guidelines do not provide criteria relevant to this request. When looking at the Official Disability Guidelines, an ultra sling would not be indicated. While it is noted the claimant has undergone a shoulder surgery and arthroscopy there is no pre-operative indication of massive or large rotator cuff tear that would require repairing. Ultra slings are typically reserved for large or massive rotator cuff repair procedures. Without evidence of this finding on claimant's preoperative imaging or operative report the request for an ultra sling would not be indicated. Therefore, the request is not medically necessary.

**Post-Operative Physical Therapy (2 times per week for 4 weeks): Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Based on California MTUS Postsurgical Rehabilitative Guidelines eight initial sessions of physical therapy would be indicated. This individual has undergone a shoulder arthroscopy decompression and rotator cuff/labrum assessment. The role of eight initial sessions of physical therapy would satisfy the Postsurgical Guideline criteria and would be indicated. Therefore, the request is medically necessary.

**Pre-Operative Clearance: 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Independent Medical Examinations and Consultations, page 127

**Decision rationale:** The California ACOEM Practice Guidelines would not support preoperative clearance. While this individual has undergone shoulder arthroscopy the medical

records do not document any underlying comorbidity or past medical history that would have necessitated preoperative assessment before the surgical process. Without documentation of medical illness, diagnosis or comorbidity to support medical assessment the need for this request would not be supported. Therefore, the request is not medically necessary.

**Pre-Operative Laboratory Tests:** 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Independent Medical Examinations and Consultations, page 127

**Decision rationale:** The California ACOEM Practice Guidelines would not support preoperative lab testing. Specific to this claimant shoulder surgery there is no indication as to the specific testing being recommended. While some testing may be indicated to satisfy hospital or anesthesia guidelines, without documentation of the specific testing being requested this clinical request would not be supported as medically necessary.