

<b>Case Number:</b>	CM14-0160248		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	09/28/2009
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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. 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

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 sustained a work related injury on 09/26/2009, after being pulled to the ground while working at a wedding, hitting the shoulder, hip and legs. A MRI of the right shoulder dated June 18, 2014, noted hypertrophy and degeneration of the acromioclavicular joint, mild supraspinatus tendinosis, no full thickness tear, and a labral signal abnormality, cannot exclude a small labral tear, with a very prominent subscapularis tendinosis. The injured worker's conservative treatments were noted to have included chiropractic care, physical therapy, and oral medications. The injured worker was noted to have had previous right shoulder surgery. The surgical report was not included in the documentation provided. The Primary Treating Physician's report dated August 7, 2014, noted the injured worker with pain and limited motion of the right shoulder, pain, clicking, popping, and swelling of the right knee, and difficulty sleeping secondary to the pain. Physical examination was noted to show the right shoulder with increased pain with motion, tenderness present over the AC joint, Neer sign, Hawkins test, and Apley scratch test all positive, with generalized weakness noted throughout motion. The lumbar spine was noted to have paraspinal tenderness with spasm noted in the lower lumbar region. The right knee was noted to have tenderness along the medial and lateral joint line, mild effusion, and increased pain with motion. The diagnoses were noted as rotator cuff injury, right shoulder, with impingement syndrome, disc bulge, lumbar spine, with right sided sciatica, internal derangement of the right knee, sleep disorder, and clinical depression. The injured worker was noted to be temporarily totally disabled. The Physician requested authorization for a right shoulder subacromial decompression, right shoulder sling, a cold unit, a CPM machine and pad kit, and

post-operative physical therapy three times a week for four weeks to the right shoulder. On September 5, 2014, Utilization Review evaluated the request for a right shoulder subacromial decompression, right shoulder sling, a cold unit, a CPM machine and pad kit, and post-operative physical therapy three times a week for four weeks to the right shoulder, citing the MTUS American Occupational and Environmental Medicine (ACOEM), the MTUS Postsurgical Treatment Guidelines, and the Official Disability Guidelines (ODG). The UR Physician noted the injured worker had prior shoulder surgery without benefit, the MRI showed tendinosis with no rotator cuff tear or impingement, and that there was no documentation of any recent injections. The UR Physician noted that in the absence of documented injection or surgical lesion, repeat surgery was not supported, therefore the request for a right shoulder subacromial decompression was not supported as medically necessary, and was not approved. The UR Physician noted that as the surgery was not supported, the requests for a right shoulder sling, a cold unit, a CPM machine and pad kit, and post-operative physical therapy three times a week for four weeks to the right shoulder were also not supported. The decisions were subsequently appealed to Independent Medical Review.

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

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

**Right shoulder subacromial decompression:** Upheld

**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): 209-210.

**Decision rationale:** According to the 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. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 8/7/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 8/7/14 does not demonstrate evidence satisfying the above criteria except for impingement signs. Therefore the determination is for non-certification.

**Right shoulder sling:** 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 Shoulder, Sling

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Cold Unit:** 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 Shoulder, Continuous flow cryotherapy

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**CPM machine/pad kit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Continuous Flow Cryotherapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, CPM

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-Op physical therapy 3 x 4:** Upheld

**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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.