

<b>Case Number:</b>	CM14-0217784		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	03/16/2009
<b>Decision Date:</b>	03/09/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/29/2014

### 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: Minnesota, Florida  
 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:

This 64 year old female continues to complain of continued right shoulder pain stemming from a work related injury reported on 3/16/2009. Diagnoses include: cervical and lumbar discogenic syndrome; carpal tunnel syndrome; shoulder pain; cauda equina syndrome; and urinary incontinence. Treatments have included: consultations; diagnostic & imaging studies; injection therapy; and medication management. The injured worker (IW) is noted to be temporarily totally disabled and not back to work. The primary physician PR-2 reports from the dates of 4/9/10/2014 through 12/19/2014 are hand written and mostly illegible, neither physical therapy, nor failing physical therapy is mentioned on these. The pain management follow-up report dated 7/23/2014 mentions the IW had attended physical therapy 2 or 3 times a week for 4 weeks, in June 2009, which provided her temporary relief. No medical record reports prior to 4/18/2014 were available for my review. On 12/4/2014 Utilization Review non-certified, for medical necessity, the requests for outpatient right shoulder surgery; pre-operative consult for medical clearance; DME; and post-operative physical therapy 3 x 4 stating that the request for surgery does not meet ODG and ACOEM guidelines for the shoulder and shoulder surgery because the documentation did not document any physical therapy visits or their functional outcome; and that no actual radiology report was submitted for review.

### 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, distal clavicle resection, rotator cuff and/or labral debridement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Diagnostic arthroscopy, Surgery chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

**Decision rationale:** The injured worker complains of right shoulder pain due to cumulative trauma. Per examination of 10/24/2014 abduction and flexion were 145, external rotation 90 with crepitation, and there was point tenderness over the supraspinatus tendon, the greater tuberosity, and the biceps tendon. Strength was 4/5 in all directions. There was tenderness over the acromioclavicular joint. Impingement testing was positive. Per medical report, an MRI dated March 4, 2014 revealed subacromial impingement, acromioclavicular arthritis, and narrowing of the sub-acromial outlet. The radiology report is not submitted. A request for right shoulder arthroscopy, subacromial decompression, distal clavicle resection, rotator cuff and/or labral debridement, preoperative medical clearance, CPM device 45 days, Surgi Stim unit 90 days, cool care cold therapy unit, postoperative physical therapy 34 was noncertified by utilization review as there was no documentation of a recent comprehensive conservative treatment program with physical therapy and injections and documented failure. Also radiology reports were not available to make an accurate assessment about the surgical request. California MTUS guidelines indicate surgical considerations for activity limitation 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, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term from surgical repair. This surgery for impingement syndrome is usually arthroscopic decompression. The procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections can be carried out for at least 3-6 months before considering surgery. Based upon the above guidelines, a recent comprehensive exercise program with 2-3 corticosteroid injections over 3-6 months is necessary before considering surgery. Radiology reports will also be necessary for surgical considerations. Although the documentation indicates conservative treatment in the past, no recent trial/failure is reported. As such, the request for arthroscopy with subacromial decompression and possible debridement of rotator cuff and/or labrum and distal claviclectomy is not supported and the medical necessity is not substantiated.

**Associated surgical service: pre-op medical clearance:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

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

**Associated surgical service: CPM device for 45 days: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

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

**Associated surgical service: surgi-stim unit for 90 days: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

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

**Associated surgical service: coolcare cold therapy unit: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

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

**Associated surgical service: post-op physical therapy, 3 times a week for 4 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

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