

<b>Case Number:</b>	CM14-0217987		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	08/10/2010
<b>Decision Date:</b>	03/11/2015	<b>UR Denial Date:</b>	12/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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 67 year old female sustained work related industrial injuries on August 10, 2010. The mechanism of injury involved a slip and fall causing injury to the right hip, right thigh, back and right shoulder. The injured worker subsequently complained of right shoulder pain. Prior treatment consisted of MRI of right shoulder, prescribed medications, six physical therapy sessions, one cortisone injection, consultation and periodic follow up visits. Provider noted that MRI of the right shoulder on November 5, 2013, revealed a right shoulder impingement syndrome with partial thickness supraspinatous tendon tear and acromioclavicular degenerative joint disease. Radiographic imaging report was not submitted for review. Per treating provider report dated November 10, 2014, the injured worker complained of unrelieved shoulder pain with a pain level 7-8/10. Physical exam revealed decreased range of motion in the right shoulder, severe supraspinatus tenderness on the right and right mild bicep tenderness. AC joint compression test, Impingement I,II,II test were all positive on the right. Provider noted that the injured worker had persistent right shoulder pain despite all aggressive conservative attempts including, physiotherapy, one cortisone injection, anti-inflammatory and analgesic medications. As of November 12, 2014, the injured worker remains temporarily totally disabled. The treating physician prescribed services for arthroscopic evaluation, arthroscopic right shoulder decompression, distal clavicle resection and rotator cuff debridement and/or repair, standard pre-operative medical clearance, supervised post-operative rehabilitative therapy, three times a week for four weeks, home continuous passive motion (CPM) device for forty-five days, Surgi-Stim unit for ninety days, then purchase and Coolcare cold therapy unit now under review. On

December 15, 2014 , the Utilization Review (UR) evaluated the prescriptions for arthroscopic evaluation, arthroscopic right shoulder decompression, distal clavicle resection and rotator cuff debridement and/or repair, standard pre-operative medical clearance, supervised post-operative rehabilitative therapy, three times a week for four weeks, home continuous passive motion (CPM) device for forty-five days, Surgi-Stim unit for ninety days, then purchase and Coolcare cold therapy unit requested on December 8, 2014. Upon review of the clinical information, UR non-certified the request for arthroscopic evaluation, arthroscopic right shoulder decompression, distal clavicle resection and rotator cuff debridement and/or repair, standard pre-operative medical clearance, supervised post-operative rehabilitative therapy, three times a week for four weeks, home continuous passive motion (CPM) device for forty-five days, Surgi-Stim unit for ninety days, then purchase and Coolcare cold therapy unit. The UR decision was based on lack of sufficient clinical documentation to support the medical necessity for the surgery, and the recommendations of the MTUS and the Official Disability Guidelines. Additionally, since the surgical procedure was denied, the subsequent request for preoperative clearance, post-operative therapy, CPM, Surgi-Stim and cold therapy were also denied. This UR decision was subsequently appealed to the Independent Medical Review.

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

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

**Arthroscopic evaluation, arthroscopic right shoulder decompression, distal clavicle resection and rotator cuff debridement and or repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Surgery Chapter, surgery for impingement syndrome; Acromioplasty

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

**Decision rationale:** The injured worker has evidence of impingement syndrome with a partial thickness rotator cuff tear and acromioclavicular arthritis. California MTUS guidelines indicate 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. 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. The documentation does not indicate evidence of such a nonoperative comprehensive treatment program. Therefore the request for arthroscopy of the right shoulder with subacromial decompression, distal clavicle resection, and rotator cuff debridement or repair is not supported and as such, the medical necessity of the request is not substantiated.

**Standard pre-operative 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): 211, 213.

**Decision rationale:** The requested surgery is not medically necessary. Therefore the ancillary services are also not medically necessary.

**Supervised post operative rehabilitative therapy, three times a week for four 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): 211, 213.

**Decision rationale:** The requested surgery is not medically necessary. Therefore the ancillary services are also not medically necessary.

**Home continuous passive motion (CPM) device for forty-five 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): 211, 213.

**Decision rationale:** The requested surgery is not medically necessary. Therefore the ancillary services are also not medically necessary.

**Surgi-Stim unit for ninety days, then purchase:** 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): 211,213.

**Decision rationale:** The requested surgery is not medically necessary. Therefore the ancillary services are also not medically necessary.

**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): 211, 213.

**Decision rationale:** The requested surgery is not medically necessary. Therefore the ancillary services are also not medically necessary.