

<b>Case Number:</b>	CM15-0112035		
<b>Date Assigned:</b>	06/23/2015	<b>Date of Injury:</b>	02/05/2013
<b>Decision Date:</b>	09/04/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2015

### 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, Indiana, Oregon  
 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 is a 55 year old male, who sustained an industrial injury on 02/05/2013. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having status post bilateral shoulder injuries with an increase in pain, status post right shoulder decompression, distal clavicle resection, along with labral and cuff debridement, and magnetic resonance imaging confirmed contralateral left shoulder impingement partial thickness rotator cuff tear. Treatment and diagnostic studies to date has included status post arthroscopic right shoulder subacromial decompression, distal clavicle resection (Mumford procedure), extensive debridement of a partial thickness undersurface rotator cuff tear, extensive debridement of superior labrum degenerative type I superior labrum anterior and posterior, and debridement of biceps tendon partial thickness tear performed on 11/14/2014, physical therapy, and magnetic resonance imaging of the left shoulder. In a progress note dated 04/24/2015 the treating physician reports complaints of bilateral shoulder pain along with stiffness and tenderness to the right shoulder. Examination reveals decreased range of motion to left shoulder, positive Hawkin's and Neer impingement signs, pain with cross body adduction, and a decrease motor strength to the left rotator cuff muscles. The treating physician requested left shoulder arthroscopy with possible arthroscopic decompression with acromioplasty, resection of coracoacromial ligament and/or bursae, Mumford procedure and right shoulder manipulation under anesthesia with the treating physician noting that the injured worker is an excellent candidate for the above listed procedures to the left shoulder along with noting the manipulation to the right shoulder for right shoulder capsulitis. The treating physician also had multiple requests related to the above noted

procedures including pre-operative clearance with urine toxicology with the treating physician noting a standard pre-operative medical clearance with a physician prior to surgery; a request for post-operative physical therapy three times a week for six weeks to reduce the pain and swelling along with assisting in regaining motion and strength; a request for a continuous passive motion machine to be used at home post-operatively noting the risk of the development of adhesions and soft tissue contracture when there is no restoration of motion that may occur secondary to pain and weakness post-operatively; a request for a deep vein thrombosis compression unit with bilateral sleeves with a 30 day rental to be used post-operatively noting that the injured worker will have a decrease ability to ambulate post-surgery causing an increase the risk for deep vein thrombosis and pulmonary embolism; and a request for an electrical stimulation unit and a cold therapy unit noting that these modalities will help with post-operative swelling and pain along with the electrical stimulation unit providing re-education of the muscles to allow for an earlier return to activities of daily living and full participation in therapy. The treating physician requested a sling with a large abduction pillow; and an assistant surgeon, but the documentation provided did not indicate the specific reasons for the requested equipment and surgeon.

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

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

**Left shoulder arthroscopy possible arthroscopic decompression with acromioplasty, resection of coracoacromial ligament and/or buras, Mumford procedure and right should manipulation under anesthesia: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of surgery for adhesive capsulitis. Per ODG shoulder section, the clinical course of this condition is self-limiting. There is insufficient literature to support capsular distention, arthroscopic lysis of adhesions/capsular release or manipulation under anesthesia (MUA). The requested procedure is not recommended by the guidelines and therefore is not medically necessary.

**Assistant surgeon: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Preoperative medical clearance to include an urine toxicology: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Post operative physical therapy, three times a week for six weeks: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated Surgical Service: Cold therapy unit: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated Surgical Service: E-stim: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated Surgical Service: Sling with large abduction pillow: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated Surgical Service: DVT compression unit with bilateral sleeves, 30 day rental:**  
Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated Surgical Service: CMP unit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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