

<b>Case Number:</b>	CM15-0173834		
<b>Date Assigned:</b>	09/15/2015	<b>Date of Injury:</b>	04/05/2014
<b>Decision Date:</b>	10/22/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2015

### 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, Oregon, Washington  
 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 59 year old male, who sustained an industrial injury on April 5, 2014. He reported pain in his back, neck, shoulders, arms, wrists, hands, knees and abdomen due to constant and repetitive movements. The injured worker was diagnosed as having cervical spine sprain and strain, lumbar spine sprain and strain, bilateral shoulder sprain and strain, bilateral wrist sprain and strain, bilateral hand-finger sprain and strain, bilateral knee sprain and strain, abdomen left inguinal hernia, post traumatic stress disorder and sleep disorder. Treatment to date has included diagnostic studies, chiropractic treatment, physical therapy, massage, knee brace and medication. On July 10, 2015, the injured worker complained of right shoulder pain rated a 3 on a 0-10 pain scale and left shoulder pain rated a 7 on the pain scale. The left shoulder pain radiated to the arm and hand associated with numbness and tingling. The pain was noted to be "relieved" with medication. Physical examination of the left shoulder revealed subacromial and rotator cuff tenderness along with external rotation weakness. Neer's sign and O'Brien's test were positive. Current diagnoses included right shoulder rotator cuff tear, left shoulder impingement syndrome and left shoulder superior glenoid labrum lesion. The treatment plan included right shoulder scopa arthroscopic surgery with subacromial decompression and rotator cuff repair surgery and left shoulder scopa arthroscopic surgery with subacromial decompression and labral repair. A request was made for left shoulder arthroscopy with subacromial decompression and labral repair and a water circulating cold pad with pump times four weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy with subacromial decompression and labral repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder section, acromioplasty surgery.

**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 7/10/15. 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 7/10/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is for non-certification and therefore is not medically necessary.

**Water circulating cold pad with pump x 4 weeks:** 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, and Continuous flow cryotherapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore the determination is for non-certification. As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.