

<b>Case Number:</b>	CM15-0176295		
<b>Date Assigned:</b>	09/17/2015	<b>Date of Injury:</b>	05/19/2004
<b>Decision Date:</b>	10/19/2015	<b>UR Denial Date:</b>	09/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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:

This is a 66-year-old female worker who was injured on 5-19-2004. The medical records indicated the injured worker was treated for right shoulder pain and weakness; status post right shoulder surgery in the past; right shoulder chronic rotator cuff tear, progressive; and right shoulder painful acromioclavicular osteoarthritis. The progress notes (7-29-15 and 8-26-15) indicated the IW had pain in the right shoulder rated 5 to 10 out of 10. Overall range of motion of the shoulder was restricted and was accompanied by popping and clicking sensations. She previously had six weeks of physical therapy, a cortisone injection and was prescribed medications. She was on modified duty. On physical examination (7-29-15 and 8-26-15) the IW's condition was unchanged. There was tenderness at the right acromioclavicular joint and impingement area. She had 150 degrees of flexion and abduction and 30 degrees of external rotation of the right shoulder with internal rotation to L4. There was a painful arc of motion. Strength was 4- with resisted abduction and resisted external and internal rotation, with 1+ pain. MRI of the right shoulder on 8-13-15 showed postoperative changes from prior decompression, a full-thickness retracted tear of the supraspinatus and a mild partial tearing of the subscapularis; a large effusion was also present. A Request for Authorization dated 8-27-15 was received for right shoulder arthroscopy, decompression, Mumford procedure, rotator cuff repair; post-operative physical therapy (right shoulder) two to three times a week for four to six weeks; Vascutherm unit (rental or purchase); and a shoulder pad. The Utilization Review on 9-4-15 modified the request for right shoulder arthroscopy to allow right shoulder arthroscopy, Mumford procedure, rotator cuff repair, as the ODG guidelines do not recommend decompression with full thickness rotator cuff repair; requested post-operative physical therapy (right shoulder) was modified to allow three sessions a week for four weeks per CA MTUS

guidelines; and the request for a Vascutherm unit was modified to allow a seven-day rental of a cold therapy unit, as there were no clinical indications for the use of vasocompression and it is not recommended by ODG-TWC guidelines. The shoulder pad was certified.

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

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

#### **Right shoulder arthroscopy, decompression, Mumford procedure, rotator cuff repair:**

Overtaken

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Shoulder Procedure Summary; ODG Indication for Surgery - Rotator cuff repair; Partial Claviclectomy.

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

**Decision rationale:** Based upon the CA MTUS Shoulder Chapter Pgs 209-210 recommendations are made for surgical consultation when there are red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection.

Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case, the exam note from 8/26/15 and the imaging findings from 8/13/15 to demonstrate significant osteoarthritis and clinical exam findings to warrant distal clavicle resection. Therefore, the determination is for certification, and is medically necessary.

#### **Post-operative physical therapy 2-3 times a week for 4-6 weeks for the right shoulder:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

**Decision rationale:** Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of postsurgical treatment visits allowable are: Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks. Sprained shoulder; rotator cuff (ICD9 840; 840.4): Postsurgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks. The guidelines recommend initial course of therapy to mean one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in the guidelines. In this case the requested number of visits exceeds this initial course of therapy. Therefore the determination is for non-certification, therefore is not medically necessary.

**Associated surgical service: Vascutherm unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.  
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Shoulder Procedure Summary.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, Cold compression therapy, it is not recommended in the shoulder as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. As the guidelines do not recommend the requested DME, the determination is for non-certification, therefore is not medically necessary.