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| <b>Case Number:</b>   | CM15-0042930 |                              |            |
| <b>Date Assigned:</b> | 03/13/2015   | <b>Date of Injury:</b>       | 03/19/2013 |
| <b>Decision Date:</b> | 05/29/2015   | <b>UR Denial Date:</b>       | 02/23/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/06/2015 |

### 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: 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:

The injured worker is a 39 year old female, who sustained an industrial injury on 3/19/2013. Diagnoses included shoulder impinging syndrome, stiffness shoulder and superior glenoid labrum tear. Treatment to date has included medications, home exercise, activity modification, injections and diagnostics. Per the Primary Treating Physician's Progress Report dated 1/28/2015, the injured worker reported right shoulder pain and weakness. Physical examination of the right shoulder revealed tenderness to palpation over the medial border of the scapula. There was scapular dyskinesia with range of motion of the shoulder. Active range of motion testing revealed forward flexion 90 degrees, abduction 90 degrees and internal rotation to L5. There was a positive Neer's test and positive Hawkin's impingement sign. The plan of care included surgical intervention and authorization was requested for right shoulder arthroscopic subacromial decompression, distal clavicle resection and debridement, assistant surgeon, pre-op labs, post-op physical therapy (2x6), sling, cold therapy unit and deep vein thrombosis (DVT) prevention unit and supplies. Utilization review certified the requests with the exception of partial claviclectomy, cold therapy unit for unspecified rental or purchase, and DVT prevention unit and supplies. ODG guidelines were cited. These requests have been appealed to an independent medical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopic subacromial decompression, distal clavicle resection and 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-Treatment in Workers' Compensation (ODG-TWC) Shoulder Procedure Summary last updated 08/27/2014.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Mumford procedure.

**Decision rationale:** The request for arthroscopy with subacromial decompression has been certified by utilization review. The disputed request pertains to the Mumford procedure or partial claviclectomy. ODG guidelines for a Mumford procedure or partial claviclectomy include conservative care for 6 weeks, subjective clinical findings of pain at the acromioclavicular joint, aggravation of pain with shoulder motion or carrying weight or previous grade 1 or 2 before meals separation plus objective clinical findings of tenderness over the acromioclavicular joint with pain relief obtained from injection of anesthetic for diagnostic purposes plus imaging clinical findings of posttraumatic changes of acromioclavicular joint or severe degenerative joint disease of acromioclavicular joint or complete or incomplete separation of the acromioclavicular joint and bone scan is positive for acromioclavicular joint separation. The documentation submitted does not indicate severe degenerative changes in the acromioclavicular joint or a prior acromioclavicular separation. As such, the request for a Mumford procedure is not supported by guidelines and the medical necessity of the request has not been necessary.

**Associated surgical service: Cold therapy unit (rental or purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation (ODG-TWC) Shoulder Procedure Summary last updated 08/27/2014.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

**Decision rationale:** Continuous-flow cryotherapy is recommended by ODG guidelines for 7 days after arthroscopic surgery of the shoulder. It reduces pain, swelling, inflammation, and the need for narcotics after surgery. Use beyond 7 days is not recommended. Therefore, the utilization review modification of the request to 7 days is appropriate. The request as stated for a cold therapy unit, unspecified duration of rental or purchase is not supported by guidelines and the medical necessity of the request has not been necessary.

**Associated surgical service: DVT prevention unit and supplies (rental or purchase):**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation (ODG-TWC) Shoulder Procedure Summary last updated 08/27/2014.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Venous thrombosis.

**Decision rationale:** ODG guidelines recommend monitoring of the risk of perioperative thromboembolic complications in both the acute and subacute postoperative periods for possible treatment and identifying subjects who are at high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. The risk of deep vein thrombosis in shoulder surgery is very small, 1 case per 1000 is reported after arthroscopy. As such the need for prophylaxis is not supported. Therefore the request for DVT prevention unit and supplies for rental or purchase is not supported by guidelines and the medical necessity of the request has not been substantiated.