

<b>Case Number:</b>	CM15-0078081		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	03/10/2014
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/23/2015

### 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: Illinois, California, Texas  
 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 57-year-old female who sustained an industrial injury on 3/10/14. Injury occurred when she went to sit in a rolling chair and the chair moved, causing her to fall backwards and toward the right side. She extended her right arm to break her fall with immediate pain in the right shoulder, wrist, and hand. Conservative treatment had included medications, physical therapy, and 3 right shoulder corticosteroid injections with temporary relief of symptoms. The 7/14/14 right shoulder MRI impression documented supraspinatus and subscapularis tendinosis with partial thickness supraspinatus tear. There was moderate acromioclavicular (AC) hypertrophic degenerative change. There was thickening of the coracoacromial ligament which could be associated with rotator cuff impingement. There was small bursal fluid within the subacromial-subdeltoid space which might indicate mild bursitis. The 3/9/15 treating physician report cited current grade 8/10 right shoulder pain. Pain has continued since the date of injury despite all attempts at aggressive conservative management. Imaging of the right shoulder revealed a partial thickness delaminating intrasubstance tear of the right supraspinatus tendon with AC degenerative joint disease. Physical exam documented right shoulder range of motion limited to forward flexion 90, extension 40, abduction 90, adduction 40, and external rotation 80 degrees with pain and positive subacromial crepitus. There was severe tenderness over the supraspinatus and AC joint, moderate tenderness over the greater tuberosity, and mild tenderness over the biceps tendon. Right shoulder muscle strength was 4/5 globally. Impingement tests I, II, and III were positive on the right. The left shoulder exam documented full pain free range of motion, no tenderness, negative orthopedic and provocative

testing, and normal strength. The diagnosis was right shoulder partial thickness rotator cuff tear and impingement. The treatment plan recommended right shoulder surgery. Authorization was requested for arthroscopic right shoulder decompression, distal clavicle resection, rotator cuff repair and bursal debridement, arthroscopic left shoulder decompression, distal clavicle resection, rotator cuff debridement and/or repair as indicated followed by manipulation under anesthesia and possible capsular release, home continuous passive motion (CPM) device, initial period of forty-five (45) days, Surgi-Stim unit, initial period of ninety (90) days, and Coolcare cold therapy unit. The 4/3/15 utilization review modified the request for right shoulder decompression, distal clavicle resection, rotator cuff repair and bursal debridement to right shoulder arthroscopy, subacromial decompression, distal clavicle excision, and possible rotator cuff repair. The request for left shoulder surgery was non-certified as there was no documentation of left shoulder pathology that would warrant surgical intervention. The request for Surgi-Stim for 90 days rental was modified to 30 day rental consistent with post-operative TENS unit guidelines. The request for a Coolcare cold therapy unit was modified to 7-day rental of a cryotherapy unit. The request for a home continuous passive motion device was non-certified as there was no documentation of adhesive capsulitis.

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

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

**Arthroscopic right shoulder decompression, distal clavicle resection, rotator cuff repair and bursal debridement:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome; Surgery for rotator cuff repair; Partial claviclectomy.

**Decision rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines provide criteria for partial claviclectomy which generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have been met. This injured worker presents with persistent right shoulder pain with severe rotator cuff and acromioclavicular tenderness. Clinical exam findings were consistent with imaging evidence of rotator cuff tear, bursitis and impingement. Detailed evidence of a

recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

**Arthroscopic left shoulder decompression, distal clavicle resection, rotator cuff debridement and/or repair as indicated followed by manipulation under anesthesia and possible capsular release: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. Guideline criteria have not been met. This injured worker presents with no documentation of subjective complaints, objective findings or imaging evidence of left shoulder pathology to support the medical necessity of this request. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the left shoulder and failure has not been submitted. There is no left shoulder related diagnosis documented by the treating physician. Therefore, this request is not medically necessary.

**Associated surgical service: Home continuous passive motion CPM device; Initial period of forty-five (45) days: 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, Continuous passive motion (CPM).

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

**Decision rationale:** The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is not recommended for shoulder rotator cuff problems or after shoulder surgery, except in cases of adhesive capsulitis. These units are recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. This injured worker presents with range of motion findings suggestive of adhesive capsulitis. Use of a CPM unit for this patient would be reasonable up to 30 days. The current request exceeds guideline recommendations. Therefore, this request is not medically necessary.

**Associated surgical service: Surgi-Stim unit; Initial period of ninety (90)days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Therefore, this request is not medically necessary.

**Associated surgical service: Coolcare cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Shoulder Chapter, Continuous-flow cryotherapy.

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

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 4/1/15 utilization review decision modified this request to cryotherapy unit for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.