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| <b>Case Number:</b>   | CM13-0001825 |                              |            |
| <b>Date Assigned:</b> | 05/02/2014   | <b>Date of Injury:</b>       | 03/11/2013 |
| <b>Decision Date:</b> | 06/11/2014   | <b>UR Denial Date:</b>       | 07/03/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/17/2013 |

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is an employee of [REDACTED] and has submitted a claim for right shoulder pain associated with an industrial injury date of March 2013. Treatment to date has included medications, right subacromial decompression and debridement of anterior superior labral tear (July 18, 2013), and post-operative physical therapy. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of minimal right shoulder pain and was not using medications. On physical examination, there was no atrophy of the right shoulder with full range of motion noted. Impingement, Speed's, and Empty Can tests were negative. Right shoulder x-ray dated June 15, 2013 revealed small subacromial spur. Utilization review from July 2, 2013 denied the request for right shoulder decompression and debridement because the rotator cuff tear was at the subscapularis, so it never got close enough to the subacromial space to be impinged; possible RCR (rotator cuff repair) because the rotator cuff tear was partial thickness; assistant surgeon because there was no unusual or stressful positioning or retraction or instrument handling for an assistant; post-op physical therapy (X8-32) because there was no indication that the patient was at increased risk for adhesive capsulitis; and Keflex, Zofran, Ibuprofen, Colace, and Vitamin C because it was not clear whether these medications were to be used post-operatively.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT SHOULDER DECOMPRESSION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 211.

**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 Chapter, Surgery for Impingement Syndrome.

**Decision rationale:** CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). In addition, ODG states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). Criteria for anterior acromioplasty include conservative care for 3 to 6 months; subjective findings of pain with active arc motion 90 to 130 degrees and pain at night; objective findings of weak or absent abduction and tenderness over the rotator cuff and positive impingement sign; and imaging findings showing positive evidence of impingement. In this case, the medical records did not state whether conservative care was done prior to the requested procedure. Furthermore, imaging findings in the records for review only included a right shoulder x-ray dated June 15, 2013 revealing a small subacromial spur. No other imaging studies showing evidence of impingement were available. The criteria were not met; therefore, the request for Right Shoulder Decompression is not medically necessary.

**DEBRIDEMENT:** 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.

**POSSIBLE RCR (ROTATOR CUFF REPAIR):** 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), Indications for Surgery- Rotator Cuff Repair.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**Decision rationale:** According to pages 210-211 of the ACOEM Practice Guidelines as referenced by CA MTUS, rotator cuff repair is supported for significant tears that impair activities causing weakness of arm elevation or rotation. For partial full-thickness and small tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. In this case, the patient primarily presented with impingement syndrome; however, there was no discussion regarding failure of conservative management for three months prior to the requested procedure. Therefore, the request for Possible RCR (Rotator Cuff Repair) 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.

**POST-OP PHYSICAL THERAPY (X8-32):** 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.

**KEFLEX:** 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.

**ZOFRAN:** 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.

**IBUPROFEN:** 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.

**COLACE:** 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.

**NORCO:** 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.

**VITAMIN C:** 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.