

<b>Case Number:</b>	CM13-0048216		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	10/24/2011
<b>Decision Date:</b>	03/06/2014	<b>UR Denial Date:</b>	11/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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 physician 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 a 60 year old female who reported an injury on 07/04/2008, due to handling heavy material during the performance of normal job duties. The patient reportedly sustained injury to the low back. The patient's back injury was previously treated with physical therapy, steroid injections, and medications. There was no physical evaluation of the patient's shoulder to determine the medical necessity of the patient's surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy with Subacromial Decompression and Debridement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 209-210.

**Decision rationale:** The requested right shoulder arthroscopy with subacromial decompression and debridement is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends surgical intervention for the shoulder when there is clinical evidence of a lesion and functional deficits corroborated by an imaging study that have failed to progress through a conservative treatment program. The clinical documentation submitted for review does not provide any evidence that the patient has a

shoulder injury that would benefit from this type of surgery. Additionally, there is no imaging study to support the need for surgery. The clinical documentation does not indicate that the patient has had any conservative treatment for a shoulder injury. Therefore, the right shoulder arthroscopy with subacromial decompression and debridement is not medically necessary or appropriate.

**Home Health Care x 2 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Page(s): 51.

**Decision rationale:** The requested home health care x2 weeks is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the use of home health unless the patient is home-bound on a part time or intermittent basis. The clinical documentation submitted for review does not indicate that the patient is home-bound on a part-time or intermittent basis. Therefore, the need for home health care x2 weeks is not medically necessary or appropriate.

**Pain Pump:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Post-operative Pain Pump

**Decision rationale:** The requested pain pump is not medically necessary or appropriate. Official Disability Guidelines do not support the use of a postoperative pain pump. Additionally, there is no indication that a surgical procedure is warranted for this patient. As such, the requested pain pump is not medically necessary or appropriate.

**Deep Vein Thrombosis (DVT),Prophylaxis:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Article on Deep Vein Thrombosis (DVT) in Orthopedic Surgery

**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, Venous Thrombosis

**Decision rationale:** The requested deep vein thrombosis prophylaxis is not medically necessary or appropriate. Official Disability Guidelines recommend deep vein thrombosis prophylaxis for patients who would require a period of immobilization and are at risk for developing deep vein thrombosis. The clinical documentation submitted for review does not provide any evidence that the patient is at risk for developing deep vein thrombosis or that there will be a period of immobilization that would put them at risk for development of a deep vein thrombosis. Therefore, the need for prophylactic treatment is not indicated. As such, the requested deep vein thrombosis (DVT) prophylaxis is not medically necessary or appropriate.