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| <b>Case Number:</b>   | CM13-0068291 |                              |            |
| <b>Date Assigned:</b> | 01/03/2014   | <b>Date of Injury:</b>       | 09/15/2004 |
| <b>Decision Date:</b> | 05/22/2014   | <b>UR Denial Date:</b>       | 12/11/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/19/2013 |

### 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:

This patient is a 66-year-old female packer with gradual onset of bilateral hand and right shoulder symptoms due to cumulative trauma; date of injury 9/15/04. Past medical history was positive for multiple industrial injuries to the right shoulder since 1998, and right carpal tunnel release in 2005. The 4/10/09 right shoulder MRI documented a rotator cuff and attenuation of the free edge of the tendon, and long biceps tendon tear. The 10/19/09 electrodiagnostic study findings were consistent with left carpal tunnel syndrome. The 4/26/13 treating physician report cited right shoulder pain and weakness associated with activity that occurs a few days a week, and daily right arm/hand and neck pain. Right shoulder exam noted abduction 90 degrees, forward flexion 110 degrees, and tenderness over the supraspinatus, infraspinatus and deltoid insertions. Right shoulder arthroscopy with open rotator cuff repair was requested. Medications included ibuprofen and omeprazole. The 11/15/13 progress report cited continued right shoulder and wrist pain. Exam findings noted right shoulder abduction 75 degrees with positive crank testing, and tenderness over the supraspinatus, coracoid, bicipital groove, and AC joint. The treating physician requested authorization for right shoulder arthroscopy with treatment as indicated, manipulation under anesthesia, and open rotator cuff repair. Additional requests were noted for pre-operative labs, chest x-ray, cooling unit, TENS unit, and 8 visits of post-op physical therapy. Medications included Cyclobenzaprine and Meloxicam. Urine drug screens were performed on 1/11/13, 2/5/13, and 4/26/13 with no controlled substances detected.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT SHOULDER ARTHROSCOPY WITH TREATMENT UNDER GENERAL ANESTHESIA AND OPEN REPAIR ROTATOR CUFF: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**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, Surgery For Rotator Cuff Repair, Manipulation Under Anesthesia (MUA).

**Decision rationale:** Under consideration is a request for right shoulder arthroscopy with treatment under general anesthesia and open repair rotator cuff. The California MTUS guidelines do not address rotator cuff repair for chronic injuries. The Official Disability Guidelines for rotator cuff repair of partial thickness tears require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. The ODG state that manipulation under anesthesia may be considered in cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90°). Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment has been tried and failed. Recent physical therapy directed towards gaining range of motion has not been attempted. There is no documentation of rotator cuff weakness, nighttime pain, or positive diagnostic injection test. Therefore, this request for right shoulder arthroscopy with treatment under general anesthesia and open repair rotator cuff is not medically necessary.

**URINE DRUG SCREEN: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78. Decision based on Non-MTUS Citation ODG, Pain (Chronic) Chapter, Urine Drug Testing.

**Decision rationale:** The California MTUS guidelines provide recommendations for urine drug screening in patient on opioid therapy with issues of abuse, addiction or poor pain control. The ODG recommend urine drug testing as a tool to monitor adherence to the use of controlled substance treatment, to identify drug misuse (both before and during treatment), and as an adjunct to self-report of drug use. Ongoing monitoring is supported if the patient has evidence of high risk of addiction, history of aberrant behavior, history of addiction, or for evaluation of medication compliance and adherence. It is recommended that patients at low risk for adverse outcomes be monitored randomly approximately every 6 months. Guideline criteria have not been met. This patient is not currently prescribed any controlled substances. There is no evidence of high risk of addiction, or history of aberrant behavior or addiction. Urine drug screens were performed on 1/11/13, 2/5/13, and 4/26/13 with no controlled substances detected. Therefore, this request for urine drug screen is not medically necessary.

**CHEST X-RAY:** 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 items/services are medically necessary

**RENTAL OF COOLING UNIT FOR TWO (2) WEEKS:** 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 items/services are medically necessary.

**POSTOPERATIVE PHYSICAL THERAPY (PT) TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE RIGHT SHOULDER:** 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 items/services are medically necessary.

**RENTAL OF TENS UNIT FOR TWO (2) WEEKS:** 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 items/services are medically necessary.

**LABS:** 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 items/services are medically necessary.