

<b>Case Number:</b>	CM14-0002856		
<b>Date Assigned:</b>	01/29/2014	<b>Date of Injury:</b>	08/28/2005
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	12/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 Surgeon, has a subspecialty in Shoulder and Elbow 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 injured worker is a 41-year-old female who reported injury on 08/28/2005. The specific mechanism of injury was lifting a patient, wheelchair and accompanying equipment into a medical van. The injured worker underwent an MRI of the right shoulder on 07/30/2013, which revealed no evidence of a rotator cuff tear. There was mild tendinosis consistent with intratendinous degenerative changes and involving the anterior leading edge of the supraspinatus tendon. There was no discrete tear or rupture and the rest of the rotator cuff tendons were intact. There were hypertrophic acromioclavicular (AC) joint changes, with subacromial spurring and possibly mild impingement upon the supraspinatus tendon. The injured worker underwent an x-ray of the right shoulder on 07/29/2013, which revealed mild degenerative changes in the right shoulder. The injured worker underwent an x-ray of the AC joint on the same date and the study revealed a normal right AC joint, with no evidence of separation. The documentation of 11/12/2013 revealed that the injured worker's pain was rated a 9/10. The injured worker could not turn her head to either side. The injured worker indicated that when she sits down in a chair the only thing that moves is her legs. She cannot bend forward or backwards. The diagnoses included severe exacerbation of cervical spine sprain/strain, cervical spine disc bulge at C6-7, and a 2.75 mm positive per MRI, right shoulder impingement syndrome, right AC cartilage disorder, right subacromial subdeltoid bursitis, and bicipital tendonitis. The DWC Form RFA (request for authorization) submitted indicated a request for right shoulder arthroscopy with partial resection of the distal clavicle, anterior lateral acromioplasty with resection of the coracoacromial ligament, extensive debridement of the subacromial bursa, and possible rotator cuff repair, preoperative chest x-ray, pulmonary function test (PFT), electrocardiogram (EKG), labs, postoperative durable medical equipment (DME), acupuncture and physical therapy. The documentation of 11/22/2013 revealed that the injured worker had marked pain in the right

shoulder. The injured worker had an injection into the subacromial space. The pain was decreased for five (5) days and returned. The injured worker had pain with activities and at night while at rest. The injured worker had difficulty sleeping on her right side. The physical examination of the right shoulder revealed pain of the AC joint. There was exquisite tenderness of the anterolateral aspect of the acromion. Flexion, abduction, adduction, and internal rotation caused accentuated pain. There was some mild weakness of the abductors and external rotators of the right shoulder. The diagnoses included shoulder impingement right, AC joint cartilage disorder with impingement, subacromial bursitis right, partial thickness tear rotator cuff right clinically, and tendinosis of the right rotator cuff. The treatment plan included arthroscopy with arthroscopic surgery of the right shoulder to include extensive debridement of the subacromial bursa and rotator cuff, anterior lateral acromioplasty with resection of the coracoacromial ligament, partial resection of the distal end of the right clavicle and the undersurface, possible resection of any extruded AC (which may be torn), intra-articular injections into the right shoulder, a medical clearance, durable medical equipment, postoperative medications including tramadol, Norco, and Keflex, as well as postoperative therapy and transportation. The subsequent documentation dated 01/09/2014 indicated that the injured worker had an inability to reach for objects above her shoulder level or behind her back, had nighttime pain, and impaired activities of daily living.

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

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

**Right shoulder arthroscopy including Mumford procedure, acromioplasty, coracoacromial ligament resection, bursal debridement, rotator cuff repair:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Partial Claviculectomy.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that a surgical consultation may be appropriate for patients who have red flag conditions, activity limitations for more than four (4) months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus existence of a surgical lesion, and clear clinical and imaging and evidence of a lesion that has been shown to benefit in both the long and short term from surgical repair. The preferred procedure is arthroscopic decompression, lysis and removal of the coracoacromial ligament, and possibly removal of the outer clavicle. Surgery is not indicated for patients with mild symptoms whose activities are not limited. Surgery for impingement syndrome is arthroscopic decompression and is not indicated for patients with mild symptoms who have no activity limitations. There should be documentation of conservative care including cortisone injections that can be carried out for at least three to six (3 to 6) months before considering surgery. There should be MRI evidence of impingement. The clinical documentation submitted for review indicated that the injured worker had mild tendinosis consistent with intratendinous degenerative changes and there was no discrete tear or rupture in

the rest of the rotator cuff tendons. There were hypertrophic changes at the acromioclavicular (AC) joint, with subacromial spurring and possible mild impingement upon the supraspinatus tendon. The injured worker underwent physical therapy, an injection and acupuncture and had activity limitations. The request for the acromioplasty, coracoacromial ligament resection, and bursal debridement would be supported. While the injured worker does not have a tear of the rotator cuff, the request for a rotator cuff repair would be appropriate as a tear may be found intraoperatively. The ACOEM Guidelines do not address the Mumford procedure, therefore, secondary guidelines were sought. The Official Disability Guidelines indicate that a partial claviclectomy is appropriate for patients who have a diagnosis of post traumatic arthritis in the AC joint with six (6) weeks of care directed toward symptomatic relief prior to surgery, pain at the AC joint, aggravation of pain with shoulder motion or carrying weight, tenderness over the AC joint, as well as conventional films that show post traumatic changes of the AC joint. The clinical documentation submitted for review indicated the injured worker had tenderness over the AC joint and conventional films that show post traumatic changes of the AC joint. There was documentation of the injured worker having conservative care. And pain with shoulder motion and tenderness over AC joint. This request was previously denied due to a lack of information. The submitted documentation addressed the issue. The request for the Mumford procedure would be supported. Given the above, the request for a right shoulder arthroscopy including Mumford procedure, acromioplasty, coracoacromial ligament resection, bursal debridement, and rotator cuff repair is medically necessary.

**Twelve (12) sessions of postoperative acupuncture: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines indicate that acupuncture is recommended as an adjunct to surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The time to produce functional improvement is three to six (3-6) treatments. The surgical procedure was found to be medically necessary. The request would be supported for six (6) sessions. However, the request for twelve (12) sessions would be excessive without treatment re-evaluation. Given the above, the request for twelve (12) sessions of postoperative acupuncture is not medically necessary.

**Chest x-ray, pulmonary function testing, and electrocardiogram (EKG): 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) Low Back

Chapter, Pre-operative Testing, ECG, Pre-operative Testing General, Pulmonary Chapter, Pulmonary Function Test.

**Decision rationale:** The Official Disability Guidelines indicates that chest preoperative x-rays are necessary when patients are at risk of postoperative pulmonary complications and if the results would change perioperative management. There was no documented rationale for the above. As such, it would not be supported. The Official Disability Guidelines indicates that pulmonary function testing is recommended in the pre-operative evaluation of individuals who may have some degree of pulmonary compromise and require pulmonary resection or in the pre-operative assessment of the pulmonary patient. The clinical documentation failed to indicate the injured worker had pulmonary compromise. There was no documented rationale for the above. As such, it would not be supported. The guidelines indicate that ambulatory surgery is a low risk procedure and would not need an electrocardiogram (EKG). There was no documented rationale for the above. As such, it would not be supported. Given the above, the requested for a chest x-ray, pulmonary function testing, and EKG is not medically necessary.

**Preoperative labs, drug screen, urinalysis, and urine glucose:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative Testing Laboratory.

**Decision rationale:** The Official Disability Guidelines recommend preoperative lab testing including preoperative urinalysis and random glucose testing for injured workers who are at a high risk of undiagnosed diabetes mellitus. There was no documented rationale for the above. As such, this testing would not be supported. Urine Drug Testing is appropriate where there are documented issues of abuse, addiction or poor pain control. There is a lack of documented rationale for this testing. Given the above, the request for preoperative labs, blood drug screen, urinalysis, and urine glucose is not medically necessary.

**Twelve (12) postoperative physical therapy sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 1, 27.

**Decision rationale:** The Postsurgical Treatment Guidelines indicate that the appropriate treatment for a rotator cuff repair postoperatively is twenty-four (24) visits over fourteen (14) weeks. The initial course of therapy is one (1) half the number of visits specified in the general course of therapy. The clinical documentation indicated that the injured worker was undergoing

and was approved to undergo a shoulder surgery. This request would be supported. Given the above, the request for twelve (12) postoperative physical therapy sessions is medically necessary.

**Interferential unit with supplies:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

**Decision rationale:** The Chronic Pain Guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention and should be used with recommended treatments including work, and exercise. The request as submitted failed to indicate duration of use, whether the unit was for purchase or rental and the supplies being requested. As such, the request for postoperative interferential unit with supplies is not medically necessary.

**Right shoulder brace:** 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, Postoperative abduction pillow sling.

**Decision rationale:** The Official Disability Guidelines indicate that a postoperative abduction pillow sling is recommended as an option following open repair of large and massive rotator cuff tears. The type of brace being requested was not provided. The clinical documentation failed to support the above criteria. Given the above, the request for right shoulder brace is not medically necessary.

**Cold therapy unit:** 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, Continuous Flow Cryotherapy.

**Decision rationale:** The Official Disability Guidelines recommend a continuous flow cryotherapy unit for seven (7) days postoperatively. The request as submitted failed to indicate if the request was for purchase or rental and the duration of use. As such, the request for a cold therapy unit is not medically necessary.

**Home exercise kit: 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, Home exercise kits.

**Decision rationale:** The Official Disability Guidelines recommend exercise kits. However, there was lack of documentation indicating the components for the home exercise kit. Given the above, the request for a home exercise kit is not medically necessary.

**Tramadol 50mg #60: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain Page(s): 60.

**Decision rationale:** The Chronic Pain Guidelines recommend opiates for the treatment of chronic pain. The clinical documentation submitted for review indicated the surgical procedure was approved. This request would be supported. Given the above, the request for postoperative tramadol 50 mg #60 is medically necessary.

**Norco 5/325mg #60: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain Page(s): 60.

**Decision rationale:** The Chronic Pain Guidelines recommend opiates for the treatment of chronic pain. The clinical documentation submitted for review indicated the surgical procedure was approved. This request would be supported. Given the above, the request for postoperative Norco 5/325 mg #60 is medically necessary.

**Keflex 500mg #20: 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 Hauck, R. M., & Nogan, S. (2013). The use of

prophylactic antibiotics in plastic surgery: update in 2010. *Annals of plastic surgery*, 70(1), 91-97.

**Decision rationale:** Hauck, R. M., & Nogan, S. (2013) indicates, "The indications for prophylactic antibiotics in plastic surgery remain controversial. No recent survey has been reported on the use of prophylactic antibiotics by plastic surgeons in clinical practice". The clinical documentation failed to provide a rationale for the requested medication. Given the above, the request for postoperative Keflex 500 mg #20 is not medically necessary.