

<b>Case Number:</b>	CM14-0003853		
<b>Date Assigned:</b>	02/03/2014	<b>Date of Injury:</b>	11/30/1993
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/10/2014

### 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 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 77 year old male who reported an injury on 11/30/1993 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to his neck, bilateral shoulders, bilateral wrists, bilateral knees, and bilateral feet. The injured worker was evaluated on 12/17/2013. It was documented that the injured worker had bilateral shoulder complaints of pain rated at a 10/10. Examination of the left shoulder documented decreased range of motion in all planes with tenderness throughout the acromioclavicular joint. It was also noted that the injured worker had decreased range of motion of the cervical spine with tenderness to palpation of the paraspinal musculature and decreased range of motion of the lumbar spine with a positive straight leg raising test to the right. The injured worker's diagnoses included history of cervical disc disease, lumbar disc disease with radiculitis, and significant left shoulder impingement. The injured worker's treatment at that appointment included a lumbar epidural steroid injection, continuation of a home exercise program, and medication usage. The injured worker was evaluated on 12/10/2013. It was documented that the injured worker had persistent left shoulder pain recalcitrant to extensive physical therapy and corticosteroid injections. Physical findings from that appointment included a positive impingement sign of the left shoulder, tenderness to palpation of the anterior capsular joint, 4-/5 strength of the left upper extremity. A recommendation for surgical intervention was made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **LEFT SHOULDER ARTHROSCOPIC SURGERY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, , 209 AND TABLE 9-6

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

**Decision rationale:** The ACOEM Guidelines recommends surgical intervention for the shoulder when there is clear clinical evidence corroborated by an imaging study of a lesion that has failed to respond to conservative treatment and would benefit from surgical repair. The clinical documentation submitted for review does indicate that the injured worker has physical findings of impingement syndrome. It is also noted within the documentation that the injured worker underwent an MRI of the left shoulder. However, an independent report of that MRI was not provided for review. Therefore, the appropriateness of the requested surgery cannot be determined. As such, the requested left shoulder arthroscopic surgery is not medically necessary or appropriate.

## **ROTATOR CUFF REPAIR: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, , 209 AND TABLE 9-6

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

**Decision rationale:** The ACOEM Guidelines recommends surgical intervention for the shoulder when there is clear clinical evidence corroborated by an imaging study of a lesion that has failed to respond to conservative treatment and would benefit from surgical repair. The clinical documentation submitted for review does indicate that the injured worker has physical findings of impingement syndrome. It is also noted within the documentation that the injured worker underwent an MRI of the left shoulder. However, an independent report of that MRI was not provided for review. Therefore, the appropriateness of the requested surgery cannot be determined. As such, the requested left shoulder arthroscopic surgery is not medically necessary or appropriate.

## **ACROMIOCLAVICULAR JOINT SURGERY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, , 209 AND TABLE 9-6

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

**Decision rationale:** The ACOEM Guidelines recommends surgical intervention for the shoulder when there is clear clinical evidence corroborated by an imaging study of a lesion that has failed to respond to conservative treatment and would benefit from surgical repair. The clinical documentation submitted for review does indicate that the injured worker has physical findings of impingement syndrome. It is also noted within the documentation that the injured worker underwent an MRI of the left shoulder. However, an independent report of that MRI was not provided for review. Therefore, the appropriateness of the requested surgery cannot be determined. As such, the requested left shoulder arthroscopic surgery is not medically necessary or appropriate.

**PRE-OP CLEARANCE:** 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:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**PRE-OP LABS: CBC (COMPLETE BLOOD COUNT):** 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.

**PRE-OP LABS: CMP (COMPLETE METABOLIC PANEL):** 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:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**PRE-OP LABS: PT (PROTHROMBIN TIME):** 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.

**PRE-OP LABS: PTT (PARTIAL THROMBOPLASTIN TIME):** 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.

**PRE-OP: 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:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**PRE-OP: EKG:** 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 DME (DURABLE MEDICAL EQUIPMENT): ARC SLING:** 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 DME (DURABLE MEDICAL EQUIPMENT): COLD THERAPY UNIT  
PURCHASE OR RENTAL (X14 DAYS): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTERS 8-14,

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**PHYSICAL THERAPY 3 TIMES A WEEK FOR 4 WEEKS (QTY: 12): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CA MTUS GUIDELINES, POST-SURGICAL PHYSICAL THERAPY GUIDELINES,

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.