

<b>Case Number:</b>	CM14-0006963		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	05/27/2003
<b>Decision Date:</b>	12/23/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2014

### 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 New York. 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 is a 52 year old male who suffered an industrial related injury to his right shoulder by lifting heavy objects on 5/27/03. A physician's report dated 10/31/13 noted diagnoses of cervical strain with degenerative disease, cervicobrachial radiculitis, occipital neuralgia, right shoulder pain, status post rotator cuff repair with possible recurrent tearing, left shoulder impingement syndrome with acromioclavicular joint pain and possible rotator cuff tearing, bilateral elbow strain, bilateral wrist strain with dorsal tenosynovitis and carpal tunnel syndrome, chronic pain syndrome, anxiety, and insomnia. The physician noted that from February 2013 through March 2013 the injured worker experienced increased shoulder, neck, and upper extremity complaints. A MRI of the left shoulder revealed supraspinatus tendinopathy and AC joint arthropathy. A physician's report dated 11/6/13 noted the treatment plan included the recommendation for right and left shoulder subacromial decompression, Mumford procedure, and rotator cuff repair. A physician's report dated 7/25/13 noted the left shoulder was tender over the biceps tendon and the acromioclavicular joint was tender. The supraspinatus and impingement maneuvers both produced pain. The apprehension and lift-off maneuvers were negative. The injured worker was prescribed Alprazolam ER 1mg and Tramadol 50mg. The injured worker was temporarily totally disabled. On 12/27/13 the utilization review (UR) physician denied the requests for right shoulder revision arthroscopy, assistant surgeon, Sprix nasal spray 15.75mg, Alprazolam 1mg #30, pain pump purchase, 30 day rental of a motorized hot/cold unit, purchase of a pro-sling with abduction pillow, and re-evaluation within 6 weeks. The UR physician noted there were ongoing symptoms and objective deficits in the right shoulder but there are limited correlative imaging abnormalities and a lack of documented failed conservative measures to warrant a revision surgery. Given the noncertification of surgery the peri-operative and post-operative requests are not supported to be medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Right Shoulder Revision Arthroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS shoulder pain chapter.

**Decision rationale:** This patient does not meet criteria for revision right shoulder surgery. Specifically imaging studies do not document new rotator cuff tear. The diagnosis of rotator cuff tear in the right shoulder does not include been established on physical examination findings. Additionally, the medical records do not document that the patient has exhausted a trial and failure of conservative measures to include physical therapy for right shoulder pain. The diagnosis of recurrent right shoulder rotator cuff tear has not been clearly established. The diagnosis of right shoulder impingement syndrome has not been clearly established. Surgery for revision right shoulder rotator cuff pathology is not medically necessary at this time.

### **Associated surgical services: Sprix 15.75 mg nasal spray for post-operative pain: 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)-TREATMENT IN WORKER'S COMPENSATION-SHOULDER PROCEDURE SUMMARY LAST UPDATED (6/21/2013)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS chronic pain treatment guidelines

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

### **Associated surgical services: Alprazolam 1mg #30 x 2 refills: 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 Other Medical Treatment Guideline or Medical Evidence: MTUS chronic pain treatment guidelines

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Motorized Hot/Cold Unit rental x 30 days:** 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)-TREATMENT IN WORKER'S COMPENSATION-SHOULDER PROCEDURE SUMMARY LAST UPDATED (6/21/2013)

**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.

**Associated surgical services: Pain Pump Purchase:** 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)-TREATMENT IN WORKER'S COMPENSATION-SHOULDER PROCEDURE SUMMARY LAST UPDATED (6/21/2013)

**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.

**Associated surgical services: Pro-Sling with abduction pillow purchase:** 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)-TREATMENT IN WORKER'S COMPENSATION-SHOULDER PROCEDURE SUMMARY LAST UPDATED (6/21/2013)

**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.

**Associated surgical services: Consult: Re-evaluation within 6 weeks:** 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)-TREATMENT IN WORKER'S COMPENSATION-SHOULDER PROCEDURE SUMMARY LAST UPDATED (6/21/2013)

**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.

**Associated surgical services: Assistant Surgeon:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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.