

<b>Case Number:</b>	CM14-0113706		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	09/15/2012
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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:

This 37-year-old male ranch hand sustained an industrial injury on 9/15/12. Injury occurred while pulling on a stuck sprinkler with onset of sharp pain in the front of his shoulder. Records suggest the patient attended 12 Physical Therapy sessions following the injury. The 2/7/14 left shoulder MRI impression documented bursal surface partial tearing of the supraspinatus cuff at the critical area just inferior to a down sloping anterolateral acromion. There was a possible small mid anterior labral tear. The 6/12/14 treating physician report cited 6/10 left shoulder and 5/10 left chest wall pain. The patient was refractory to care with significant decline in activity/function involving the left upper extremity. Medications provided improvement in pain and function. Objective findings documented left shoulder tenderness, markedly limited and painful range of motion, positive impingement signs and decreased cervical trapezius spasms. Left Arthroscopic Subacromial Decompression was requested. The treatment plan recommended continued TENS unit, Hydrocodone, Naproxen, Pantoprazole, and Orphenadrine. The 6/20/14 PQME report documented left shoulder pain increased on cross reaching and reaching above shoulder height; he wakes at night due to pain. Physical exam documented subacromial bursa, posterior glenohumeral joint, scapula, and latissimus dorsi tenderness to palpation. There was a painful arc of motion 90-110 degrees and normal left upper extremity strength. There was a 20-30% loss of shoulder range of motion globally. Orthopedic testing was negative for instability, impingement, rotator cuff pathology and biceps tendonitis. Disjointed treatment was documented. Additional Physical Therapy and a Subacromial Injection were recommended. The 7/3/14 utilization review denied the left shoulder arthroscopy and associated requests as there was no documentation of guideline-recommended conservative treatment.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-operative History and Physical Examination:** 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: Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93.

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

**Left Shoulder Arthroscopic Subacromial Decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation, online edition, Chapter: Shoulder; Official Disability Guidelines, Indications for surgery.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** The ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit in the short and long-term from surgical repair. Arthroscopic decompression is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive guideline-recommended conservative treatment had been tried and failed. Therefore, this request for left shoulder arthroscopic subacromial decompression is not medically necessary.

**Anesthesiologist:** 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: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation.

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