

<b>Case Number:</b>	CM14-0144987		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	04/17/2002
<b>Decision Date:</b>	11/17/2014	<b>UR Denial Date:</b>	08/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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 Pennsylvania. 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 claimant is a 44-year-old female who injured her right shoulder on April 17, 2002. The clinical records provided for review included the report of an MRI of the right shoulder dated February 24, 2014, identifying evidence of moderate supraspinatus and infraspinatus tendinopathy but no evidence of rotator cuff tearing. There was also noted to be mild acromioclavicular joint arthrosis, hypertrophy, and a down sloping acromion. The follow-up clinical report of February 25, 2014, described continued complaints of pain in the shoulder with weakness. Physical examination showed positive Hawkins and impingement testing, 5-/5 strength of the supraspinatus, and the remainder of motor examination was 5/5. There was no evidence of instability or loss of motion documented. The report documented that treatment to date consisted of medications, physical therapy, work restrictions, and a prior corticosteroid injection. A corticosteroid injection was given to the claimant and the recommendation was made for right shoulder arthroscopy, subacromial decompression, debridement, distal clavicle resection, and bicep tenodesis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Corticosteroid/Lidocaine injection to subacromial space:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

**Decision rationale:** California ACOEM Guidelines support the request for an injection of the subacromial space. The medical records document that the claimant received benefit from the injection on 02/25/14. The ACOEM Guidelines recommend two to three injections as part of conservative treatment. Therefore, based on the benefit of the prior injection, the request for another injection of the subacromial space would be recommended as medically necessary.

**Outpatient surgery right should arthroscopy, subacromial decompression, Mumford, biceps Tenotomy and Tenodesis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery, Acromioplasty and Ruptured Biceps Tendon Surgery

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 214.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Comp, 18th Edition, 2013 Updates: Shoulder Procedure: surgery for ruptured biceps tendon; Mumford Procedure

**Decision rationale:** Based on California ACOEM Guidelines and supported by the Official Disability Guidelines, the request for outpatient surgery to include right shoulder arthroscopy, subacromial decompression, Mumford, biceps tenotomy and tenodesis is not recommended as medically necessary. Although the documentation indicates that the claimant has failed conservative care, it appears that this occurred in the past. There is no documentation that the claimant has failed three to six months of current conservative care including injections. While there is evidence of continued symptoms in this individual, without documentation of recent conservative management the acute need of operative intervention would not be supported. Therefore, this request is not medically necessary.

**Preoperative laboratory tests including CBC (Complete Blood Count) and Chem (Chemistry Panel) 7:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI); 2006 Jul.33 p

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Independent Medical Examinations and Consultations, page 127

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

**Preoperative EKG (Electrocardiogram): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC (American College of Cardiology Foundation) / AHA (American Heart Association) 2007 Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 Independent Medical Examinations and Consultations, page 127

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

**Assistant Surgeon, QTY: 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicare Services, Physician Fee Schedule Search, CPT Code 64721 ([http:// www.cms.gov/apps/physician-fee-schedule/overview.aspx](http://www.cms.gov/apps/physician-fee-schedule/overview.aspx))

**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: Milliman Care Guidelines 18th edition: Assistant Surgeon Guidelines (Codes 29355 to 29901)

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

**Postoperative Sling, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder (Acute and Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Comp, 18th Edition, 2013 Updates: shoulder procedure

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

**Game Ready Unit, QTY: 14 day rental: 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): Shoulder (Acute and Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Comp, 18th Edition, 2013 Updates: knee procedure

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

**Postoperative physical therapy, QTY: 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

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