

<b>Case Number:</b>	CM14-0157655		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	09/07/2013
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 48-year-old female sustained an industrial injury on 9/7/13. Injury to the right shoulder was sustained relative to a slip and fall. Conservative treatment included activity modification, intra-articular steroid injection, physical therapy, and medications. The 3/25/14 right shoulder MRI impression documented minimal acromioclavicular joint degenerative joint disease, minimal joint effusion, and findings suggestive of cuff tendinosis, no tear was seen. The 5/27/14 initial orthopedic report documented tenderness to palpation over the acromioclavicular joint. Range of motion was slightly limited in abduction and flexion to 170 degrees. Right shoulder x-rays were taken and showed acromioclavicular joint arthritis. MRI findings were reviewed. The diagnosis was right shoulder mild impingement with supraspinatus tendinosis and acromioclavicular joint arthritis. The treatment plan recommended continued work modifications to avoid overhead activities. No surgical intervention or further physical therapy was needed. A change in physician was noted on 7/14/14. The 7/14/14 objective findings documented positive tenderness with range of motion and negative instability. Shoulder range of motion was documented as abduction 140, flexion 145, internal rotation 35, external rotation 45, and adduction 20 degrees. The treatment plan recommended Naprosyn and a right shoulder MR arthrogram. The 7/29/14 right shoulder MR arthrogram impression documented a tear of the superior/posterosuperior labrum. The biceps was normal. There was supraspinatus tendinosis and subacromial bursitis. There was moderate hypertrophy and degeneration of the acromioclavicular joint, without significant compression of the supraspinatus. The 8/18/14 treating physician report cited no improvement in the right shoulder. The patient was taking medication as prescribed with some benefit. Right shoulder exam documented tenderness with range of motion, and positive Neer's and supraspinatus tests. Range of motion testing documented forward flexion 130, abduction 130, internal rotation 30, external rotation 35, extension 30, and adduction 20 degrees. There was

no instability. Tenderness was noted at the acromioclavicular joint. MRI findings showed bursitis and superior labral tearing. The patient had failed conservative treatment with physical therapy, injections x2, and work restrictions. The treatment plan recommended right shoulder arthroscopy and subacromial decompression. The 9/3/14 utilization review denied the right shoulder surgery and associated requests as subjective and clinical exam findings did not meet guideline indications and there was no available imaging report.

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

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

**Right shoulder arthroscopy subacromial decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome

**Decision rationale:** The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. There is no current evidence of pain at night. There is no documentation of weak or absent abduction. There is no evidence of a positive diagnostic injection test. Imaging evidence indicated that there was no significant impingement. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

**Pre-operative medical clearance:** 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), Low Back Chapter, Pre-operative Testing

**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. Anesthesiology 2012 Mar; 116(3):522-38

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Pre-operative EKG (Electrocardiogram):** 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), Low Back Chapter, Pre-operative Testing

**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. Anesthesiology 2012 Mar; 116(3):522-38

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Pre-operative chest x-ray:** 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), Low Back Chapter, Pre-operative Testing

**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: ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Pre-operative laboratory testing: CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), PT (Prothrombin Time) and PTT (Partial Thromboplastin Time):** 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), Low Back Chapter, Pre-operative Testing

**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. Anesthesiology 2012 Mar; 116(3):522-38

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Post-operative physical therapy, 3 times a week for 2 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter

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

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Norco:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-80,91.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.