

<b>Case Number:</b>	CM14-0036522		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	01/19/2012
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	03/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2014

### 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, has a subspecialty in Sports Medicine and is licensed to practice in Alaska & Texas. 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 62-year-old male who reported an injury on 01/19/2012 due to repetitive trauma. The injured worker has a history of left shoulder pain. The injured worker had diagnoses of shoulder joint pain, osteoarthritis unspecified to the shoulder, adhesive capsulitis to the shoulder and disorder bursae tendinitis. The past treatments included medication, and injections. An MRI of the left shoulder was performed on 06/05/2013 which revealed attenuation and signal alteration of the distal supraspinatus tendon compatible with chronic partial-thickness tearing, probably a moderate to high grade tear, a full-thickness component could not be ruled out. The report noted there was focal moderate grade intrasubstance partial-thickness tearing of the subscapularis mid tendinous fibers at the lesser tuberosity. Moderate acromioclavicular joint osteoarthritis was seen as well as advanced glenohumeral joint osteoarthritis with full-thickness chondral loss and subchondral cystic change posteriorly, and global degenerative tearing. The report indicated there was a moderate sized glenohumeral joint effusion with mild synovitis and there was moderate tendinosis of the intra-articular long head of the biceps tendon, with possible superimposed interstitial tearing. The clinical note dated 11/04/2013 noted the injured worker had flexion to the left shoulder at 105 degrees, extension at 50 degrees, external rotation at 90 degrees, internal rotation 20 degrees, adduction 50 degrees and abduction 100 degrees. Positive Neer's and positive supraspinatus test. Grip strength in the left hand was a 22/26/22. The medication included Polar frost, Norco and Etodolac. The treatment plan included arthroscopic subacromial decompression of the left shoulder, a preoperative medical clearance and postoperative physical therapy 3 times a week for 3 weeks for the left shoulder. The authorization dated 09/05/2014 was submitted within the documentation. The rationale was not provided.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Arthroscopic Subacromial Decompression of the left shoulder.:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211-212.

**Decision rationale:** The request for arthroscopic subacromial decompression of the left shoulder is medically necessary. The California MTUS/ACOEM guidelines indicate that surgery for impingement syndrome is usually arthroscopic decompression. This procedure 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 three to six months before considering surgery. Because this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendinitis, also refer to the previous discussion of rotator cuff tears. The clinical notes reported the injured worker failed conservative care and the injured worker had positive physical examination findings. The injured worker had extensive pathology per the MRI of the left shoulder. Therefore, the proposed surgery would be indicated. As such, the request is 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 The American Academy of Orthopedic Surgeons, OKU 9, Chapter 9, page 106-113.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Preoperative testing, general.

**Decision rationale:** The request for preoperative medical clearance is not medically necessary. The Official Disability Guidelines indicate that preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. There is a lack of documentation indicating the injured worker has a significant co-morbidity for which preoperative testing would be indicated. The submitted request does not indicate the specific labs being requested. As such, the request is not medically necessary.

**Post-operative Physical Therapy three times a week for three weeks for the left shoulder.:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s):  
10.

**Decision rationale:** The request for postoperative physical therapy 3 times a week for 3 weeks for the left shoulder is not medically necessary. The California MTUS guidelines recommend 24 sessions of physical therapy over 14 weeks postoperatively. The guidelines recommend an initial course of physical therapy including one half of the recommended number of sessions of physical therapy. The surgical intervention is indicated; therefore, the requested postoperative physical therapy would be indicated. As such, the request is not medically necessary.