

<b>Case Number:</b>	CM14-0036612		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	12/30/2010
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	03/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2014

### 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 Orthopaedic 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:

The patient is a 67-year-old female who sustained an industrial injury on December 30, 2010. The injury occurred when she got out of a truck, slipped on ice and fell backward. Injuries were reported to the head, low back, bilateral wrists, bilateral knees, and right shoulder. The patient was status post right carpal tunnel release on February 11, 2013, left carpal tunnel release on March 28, 2013, and left knee arthroscopic meniscectomy with abrasion chondroplasty on July 24, 2013. The February 20, 2014 treating physician report cited complaints of bilateral shoulder, wrist, and knee pain. The main complaint is the right shoulder. There was pain with overhead activity and at night. Right shoulder exam documented full but painful range of motion with no instability. Neer and Hawkins tests were positive. There was 5/5 strength and normal sensation. The January 21, 2014 right shoulder MRI reportedly showed rotator cuff tendonitis, acromioclavicular arthrosis, superior labral tear from anterior to posterior (SLAP) lesion, glenohumeral arthrosis and bursitis. Right shoulder arthroscopy with debridement was recommended. The March 19, 2014 utilization review denied the right shoulder arthroscopy and associated requests, as there was no documentation of conservative treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy with Debridement: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Impingement syndrome.

**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 SLAP lesions.

**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 for surgical repair of SLAP lesions state that SLAP lesions may warrant surgical treatment in certain cases. Surgical intervention may be considered for patients failing conservative treatment. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive guideline-recommended conservative treatment had been tried and failed. Therefore, the request is not medically necessary.

**Pre-operative Medical Clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the request for right shoulder arthroscopy is not medically necessary, the associated request for pre-operative medical clearance is also not medically necessary.

**Pre-operative chest x-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the request for right shoulder arthroscopy is not medically necessary, the associated request for pre-operative chest x-ray is also not medically necessary.

**Pre-operative Electrocardiogram:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the request for right shoulder arthroscopy is not medically necessary, the associated request for pre-operative electrocardiogram is also not medically necessary.

**Pre-operative CBC, Chem 7, PT/PTT/INR: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the request for right shoulder arthroscopy is not medically necessary, the associated request for pre-operative CBC, Chem 7, and PT/PTT/INR is also not medically necessary.

**Post-operative Physical Therapy 2 times a week times 6 weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the request for right shoulder arthroscopy is not medically necessary, the associated request for post-operative physical therapy 2 times a week for 6 weeks is also not medically necessary.