

<b>Case Number:</b>	CM14-0064733		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	02/10/2012
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	04/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2014

### 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 44-year-old male truck driver sustained an industrial injury on 2/10/12. Injury occurred when he fell from a trailer to the ground, landing on his right arm and sustaining a fracture. The patient underwent open reduction and internal fixation of the supracondylar humeral and olecranon fracture. The 10/17/13 right upper extremity EMG was reported normal. The nerve conduction study findings were compatible with mild right ulnar neuropathy at the elbow. The 10/29/13 progress report cited a complaint of constant grade 7/10 right shoulder pain, worse with movement. Right shoulder exam documented positive Neer's, cross-over, Apley's, and Hawkin's tests. Abduction was weak against resistance. There was mild loss in right shoulder range of motion. A shoulder MRI was requested. The 12/10/13 right shoulder MRI impression documented no evidence of a rotator cuff tear. There was mild supraspinatus tendinosis with findings consistent with intra-tendinous degenerative changes. There was mild degenerative joint disease and hypertrophic acromioclavicular (AC) joint changes. A corticosteroid injection was provided on 2/7/14 with some relief for about a week or two, and then the pain returned. The 3/28/14 treating physician report documented right shoulder physical exam findings of exquisite tenderness over the anterolateral acromion and an AC joint tenderness. Shoulder flexion, adduction and internal rotation caused marked accentuated pain. The diagnosis was right shoulder impingement syndrome, AC joint cartilage disorder, subacromial/subdeltoid bursitis, bicipital tendonitis, right wrist tenosynovitis, right ulnar neuropathy, and status post open reduction and internal fixation of supracondylar humeral and olecranon fracture. The treatment plan recommended right shoulder arthroscopic surgery. The 4/17/14 utilization review denied the request for right shoulder MRI as there was no documentation of physical therapy and the patient was not convinced that he would benefit from the procedure which made the likelihood of improvement low. Records indicated that conservative treatment for the shoulder had been

limited to one corticosteroid injection, anti-inflammatory medication, pain medication, and activity modification.

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

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

**Pre-op Diagnostics : CBC, Chem 12, PT, PTT:** 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).

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

**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).

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

**EKG:** 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).

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

**Urinalysis:** 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).

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

**Arthroscopy with Arthroscopic Surgery for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. There is no clear surgical lesion identified on imaging. Therefore, this request for arthroscopy with arthroscopic surgery for the right shoulder is not medically necessary.