

<b>Case Number:</b>	CM14-0192603		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	06/20/2014
<b>Decision Date:</b>	02/03/2015	<b>UR Denial Date:</b>	11/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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:

According to the records made available for review, this is a 48-year-old male with a 6/20/14 date of injury. At the time (11/10/14) of request for authorization for right shoulder diagnostic/operative arthroscopic decompression, partial acromioplasty Qty1, right shoulder diagnostic/operative arthroscopic debridement Qty1, right shoulder diagnostic/operative arthroscopic synovectomy Qty1, right shoulder diagnostic/operative arthroscopic claviclectomy Qty1, right shoulder diagnostic/operative arthroscopic capsulorrhaphy Qty1, right shoulder diagnostic/operative arthroscopic manipulation under anesthesia Qty1, Assistant Surgeon, (associated surgical services) post-operative physical therapy right shoulder Qty 12, (associated surgical services) medical clearance CBC Qty 1, (associated surgical services) medical clearance CMP Qty 1, (Associated surgical services) medical clearance PT/PTT Qty 1, (Associated surgical services) medical clearance Hepatic Panel Qty 1, (Associated surgical services) medical clearance HIV panel Qty 1, (Associated surgical services) medical clearance UA Qty 1, (Associated surgical services) medical clearance EKG Qty 1, (Associated surgical services) medical clearance chest x-ray Qty 1, (Associated surgical services) post-operative right shoulder sling Qty 1, there is documentation of subjective (severe pain and stiffness of the right shoulder, pain rated 8/10) and objective (right shoulder forward flexion 110, abduction 130, ER 90, and IR to T8, positive Neer and Hawkins for impingement, positive O'Brien's test) findings, imaging findings (right shoulder MRI (7/17/14) report revealed joint effusion correlate clinically for posttraumatic synovitis; tendinitis which is more likely a partial intrasubstance tear of the supraspinatus tendon without evidence for a full thickness rotator cuff tear or retraction), current diagnoses (right shoulder posttraumatic tear of the rotator cuff with secondary impingement bursitis and AC joint degeneration), and treatment to date (medications and activity modification, and physical therapy). Regarding the requested right shoulder diagnostic/operative arthroscopic

decompression, partial acromioplasty Qty1, right shoulder diagnostic/operative arthroscopic debridement Qty1:, right shoulder diagnostic/operative arthroscopic synovectomy Qty1, right shoulder diagnostic/operative arthroscopic claviculectomy Qty1, right shoulder diagnostic/operative arthroscopic capsulorrhaphy Qty1, right shoulder diagnostic/operative arthroscopic manipulation under anesthesia Qty1, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and temporary relief of pain with anesthetic injection (diagnostic injection test).

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

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

**Right Shoulder diagnostic/operative arthriscope decompression, partial acromioplasty Qty1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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 Chapter, Subacromial Decompression.

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of right shoulder posttraumatic tear of the rotator cuff with secondary impingement bursitis and AC joint degeneration. In addition, there is documentation of conservative care: recommend 3 to 6 months; objective clinical findings: weak abduction; and positive impingement sign; and imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. However, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and temporary relief of pain with anesthetic injection (diagnostic injection test). Therefore, based on guidelines and a review of the evidence, the request for right shoulder diagnostic/operative arthroscopic decompression, partial acromioplasty Qty1 is not medically necessary.

**Right Shoulder diagnostic/operative arthroscopic debridement Qty1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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)

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of right shoulder posttraumatic tear of the rotator cuff with secondary impingement bursitis and AC joint degeneration. In addition, there is documentation of conservative care: recommend 3 to 6 months; objective clinical findings: weak abduction; and positive impingement sign; and imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. However, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and temporary relief of pain with anesthetic injection (diagnostic injection test). Therefore, based on guidelines and a review of the evidence, the request for right shoulder diagnostic/operative arthroscopic debridement Qty: 1 is not medically necessary.

**Right Shoulder diagnostic/operative arthroscopic synovectomy Qty1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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)

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI,

ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of right shoulder posttraumatic tear of the rotator cuff with secondary impingement bursitis and AC joint degeneration. In addition, there is documentation of conservative care: recommend 3 to 6 months; objective clinical findings: weak abduction; and positive impingement sign; and imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. However, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and temporary relief of pain with anesthetic injection (diagnostic injection test). Therefore, based on guidelines and a review of the evidence, the request for right shoulder diagnostic/operative arthroscopic synovectomy Qty1 is not medically necessary.

**Right Shoulder diagnostic/operative arthroscopic Claviclectomy Qty1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Division of Sports Medicine, Department of Orthopaedic Surgery, Rush University Medical, Chicago, Illinois 60612, USA

**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)

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of right shoulder posttraumatic tear of the rotator cuff with secondary impingement bursitis and AC joint degeneration. In addition, there is documentation of conservative care: recommend 3 to 6 months; objective clinical findings: weak abduction; and positive impingement sign; and imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. However, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and temporary relief of pain with anesthetic injection (diagnostic injection test). Therefore, based on guidelines and a review of the evidence, the request for right shoulder diagnostic/operative arthroscopic claviclectomy Qty1 is not medically necessary.

**Right Shoulder diagnostic/operative arthroscopic capsulorrhaphy Qty1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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)

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of right shoulder posttraumatic tear of the rotator cuff with secondary impingement bursitis and AC joint degeneration. In addition, there is documentation of conservative care: recommend 3 to 6 months; objective clinical findings: weak abduction; and positive impingement sign; and imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. However, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and temporary relief of pain with anesthetic injection (diagnostic injection test). Therefore, based on guidelines and a review of the evidence, the request for right shoulder diagnostic/operative arthroscopic capsulorrhaphy Qty1 is not medically necessary.

**Right Shoulder diagnostic/operative arthroscopic manipulation under anesthesia Qty1:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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)  
<

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and

temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of right shoulder posttraumatic tear of the rotator cuff with secondary impingement bursitis and AC joint degeneration. In addition, there is documentation of conservative care: recommend 3 to 6 months; objective clinical findings: weak abduction; and positive impingement sign; and imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. However, there is no documentation of subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night; and temporary relief of pain with anesthetic injection (diagnostic injection test). Therefore, based on guidelines and a review of the evidence, the request for right shoulder diagnostic/operative arthroscopic manipulation under anesthesia Qty1 is not medically necessary.

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

**(Associated surgical services) Post Operative Physical Therapy right shoulder Qty 12:**  
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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**(Associated surgical services) Medical Clearance CBC Qty 1:** 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**(Associated surgical services) Medical Clearance CMP Qty 1: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**(Associated surgical services) Medical Clearance PT/PTT Qty 1: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**(Associated surgical services) Medical Clearance Hepatic Panel Qty 1: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**(Associated surgical services) Medical Clearance HIV Panel Qty 1: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**(Associated surgical services) Medical Clearance UA Qty 1: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**(Associated surgical services) Medical Clearance EKG Qty 1: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.