

<b>Case Number:</b>	CM14-0200468		
<b>Date Assigned:</b>	12/11/2014	<b>Date of Injury:</b>	04/21/2008
<b>Decision Date:</b>	01/27/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2014

### 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 is a 61 year old male with a 4/21/08 injury date. The mechanism of injury was described as pushing a 250-pound joist and injuring the left arm. In a 3/31/14 assessment, the patient had reached maximum medical improvement (MMI). In a 10/14/14 note, the patient complained of left shoulder pain. Objective findings included left shoulder pain over the anterior lateral aspect, and positive impingement signs. A 9/8/14 left shoulder MRI revealed postsurgical changes, normal subacromial space, mild bursitis, and mild tendinosis. Diagnostic impression: left shoulder impingement syndrome. Treatment to date: left shoulder surgery x 3, medications, physical therapy, injections. A UR decision on 11/7/14 denied the request for left shoulder subacromial decompression and debridement because this patient has already had three previous left shoulder surgeries in which a subacromial decompression was performed as part of the procedure. There was no clinical information available that would suggest a need for a fourth procedure on the left shoulder. The requests for pre-op clearance, sling, cold therapy unit, physical therapy, and omeprazole were denied because the associated surgical procedure was not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Subacromial Decompression and Debridement as Needed: Upheld**

**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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Surgery for Impingement Syndrome.

**Decision rationale:** CA MTUS states that surgery for impingement syndrome is usually "arthroscopic decompression (acromioplasty)." However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include "clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair." Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. However, this patient has already had three previous left shoulder surgeries, all of which have included decompression of the subacromial space. The latest MRI shows an open subacromial space, with only mild bursitis and mild tendinosis. There is no documentation of recent conservative treatment aimed at treating this patient's recent flare-up, including physical therapy and injection. There is no documentation of objective functional limitations such as reduced range of motion or weakness. In order for this surgery to be considered, there would need to be documentation of exceptional factors that would necessitate a fourth left shoulder decompression. Therefore, the request for Left Shoulder Subacromial Decompression and Debridement as Needed is not medically necessary.

**Associated Surgical Service: Pre-Op Clearance with Internist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 12th Edition (web), 2014, Low Back Chapter, Pre-operative testing, general

**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 Service: Post-Op DME Purchase: Sling:** 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), Treatment Index, 12th Edition (web), 2014, Shoulder Chapter, Postoperative abduction pillow sling

**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 Service: Post-Op DME Rental: Cold Therapy times 10 Days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 12th Edition (web), 2014, Shoulder Chapter, Continuous-flow cryotherapy

**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 Service: Post-Operative Physical Therapy 2 Times a Week for 6 Weeks:** Upheld

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

**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.

**Omeprazole 20mg, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation FDA (Omeprazole).

**Decision rationale:** CA MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as; gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. Omeprazole is a proton pump inhibitor, PPI, used in treating reflux esophagitis and peptic ulcer disease. There is no comment that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this industrial injury. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. However, there remains no report of gastrointestinal complaints or chronic NSAID use. Therefore, the request for Omeprazole 20 mg #30 is not medically necessary.