

<b>Case Number:</b>	CM15-0003388		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	11/13/2012
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 48-year-old female, who sustained an industrial injury on 11/13/2012 when a camera broke and she tripped over it, hit her head and twisted her back. The diagnoses have included unspecified disorders bursae & tendons shoulder region, brachial plexus lesions, degeneration of cervical intervertebral disc, and contusion upper arm. Treatment to date has included modified work and activities of daily living and medications. Magnetic resonance imaging (MRI) of the left shoulder dated 4/12/2013 which was read by the evaluating provider as no acute or subacute osseous abnormality; degenerative changes, mild to moderate, at the acromioclavicular joint, and the acromion process has a mildly undersurface; there are signal alterations in the supraspinatus consistent with moderate tendinopathy with no evidence of rotator cuff tear; biceps labral complex is intact, there is a small amount of abnormal fluid in the subacromial and sub deltoid bursae consistent with bursitis. Per the progress dated 12/05/2012, The IW reported no pain. Objective findings included normal range of motion of the neck, left shoulder and back. There is no midline spinal tenderness and no tenderness or spasm of the cervical or trapezius muscles. On 10/15/2014, a repeat MRI of the left shoulder revealed an oblique full-thickness tear of the supraspinatus seen with possible extension to the rotator interval and inflammation of the subcoracoid bursa and subacromial bursa. Acromioclavicular joint arthropathy was noted. The radiologist suggested a follow-up arthrogram if clinically indicated. Electrodiagnostic studies dated October 8, 2013 revealed bilateral carpal tunnel syndrome, right more than left. On 10/15/2014 and MRI scan of the cervical spine revealed disc herniations and bulges at multiple levels, particularly at C4-5 and C5-6 and multilevel neural

foraminal narrowing due to disc osteophyte complexes. A qualified medical evaluation dated September 23, 2014 indicated complaints of pain in the neck radiating to the left shoulder, left shoulder blade, and left arm and into the upper back. She was experiencing burning pain in the left arm as well as numbness and tingling in the left hand. The shoulder pain radiated all the way down to her left wrist and hand and increased with raising her arm above her head, pushing pulling, and reaching backwards, she also experienced popping and grinding in the right shoulder increased with movement or use. There is no documentation provided about a physical therapy program pertaining to the left shoulder prior to the request for surgery. One corticosteroid injection is documented but the response is not known. On 12/23/2014 Utilization Review non-certified left shoulder arthroscopic surgery, cold therapy unit x 2 weeks, sling, CPM machine x 3 weeks, pre-op medical clearance by an internist, post-op physical therapy (2 x week x 4 months), Vicodin 5mg #90 and Flexeril 5mg #20 noting that the lack of conservative care prior to consideration for surgical intervention. The MTUS, ACOEM, and ODG were cited. On 1/07/2015, the injured worker submitted an application for IMR for review of left shoulder arthroscopic surgery, cold therapy unit x 2 weeks, sling, CPM machine x 3 weeks, pre-op medical clearance by an internist, post-op physical therapy (2 x week x 4 months), and 2 oral medications: Vicodin and Flexeril.

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

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

#### **Left Shoulder Arthroscopic Surgery: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211.

**Decision rationale:** California MTUS guidelines indicate surgical considerations for activity limitation for more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term from surgical repair. Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of the arm elevation or rotation, particularly acutely in younger workers. For partial-thickness and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. Studies of normal subjects document the universal presence of degenerative changes and conditions including full avulsions of the rotator cuff without symptoms. Conservative care including cortisone injections can be carried out for 3-6 months before considering surgery for impingement. The documentation provided does not indicate evidence of necessary conservative treatment before surgical considerations. One corticosteroid injection was documented but there has been no recent physical therapy per available records. As such, the guideline criteria have not been met and the request for arthroscopic surgery of the left shoulder is a bit premature. A trial and documented failure of a rehabilitation program is

necessary before surgical considerations. As such, the request for unspecified left shoulder arthroscopic surgery is not supported and the medical necessity is not substantiated.

**Associated Surgical Service: Cold Therapy Unit x 2 Weeks: 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 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: 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)

**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: CPM Machine x 3 Weeks: 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 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: Pre-Op Medical Clearance by An Internist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.

**Associated Surgical Service: Post-Op Physical Therapy 2 Times A Week for 4 Months: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**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: Vicodin 5 MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.

**Associated Surgical Service: Flexeril 5 MG #20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.