

<b>Case Number:</b>	CM15-0008562		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	12/12/2007
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	12/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2015

### 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: New York, New Hampshire, Washington  
 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 55 year old female, who sustained an industrial injury on 12/2/2007. The diagnoses have included chronic neck pain, impingement syndrome of the right and left shoulder and carpal tunnel syndrome status post decompression on both sides. Past medical history included diabetes mellitus and hypertension. Treatment to date has included trigger point injections, epidural injections, Transcutaneous Electrical Nerve Stimulation (TENS), chiropractic treatment and pain medications. Magnetic resonance imaging (MRI) of the right shoulder from 10/24/2014 revealed full thickness, full width tearing of the supraspinous tendon and severe hypertrophic degenerative changes at the acromioclavicular joint. According to the follow-up report from 12/9/2014, the injured worker complained of pain in her neck, both shoulders, both elbows, both wrists and hands. Objective findings included elevated blood pressure, tenderness along the right rotator cuff, biceps tendon and acromioclavicular joint with positive cross arm test. Authorization was requested for operative arthroscopy, decompression of the distal clavicle, subacromial decompression, excision of the distal clavicle, rotator cuff repair and evaluation of biceps and the labrum. On 12/29/2014 Utilization Review (UR) partially certified a request for right shoulder operative arthroscopy to right shoulder operative arthroscopy (repair of rotator cuff tear and subacromial decompression), noting that the medical necessity was established. UR partially certified a request for preoperative clearance to preoperative clearance (electrocardiogram, complete blood count with differential, basic metabolic profile (BMP) and urinalysis) noting that the documentation did not reflect a complex medical history for which referral for completion of a preoperative history and physical would be necessary. UR partially

certified a request for polar care times 21 days to continuous flow cryotherapy for 7 days rental, noting that guidelines support this treatment for 7 days postoperatively. UR non-certified a request for Augmentin, noting that it is not recommended for routine precaution. The ODG was cited.

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

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

#### **Right shoulder operative arthroscopy: 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): 209-222.

**Decision rationale:** 55 yo female with chronic shoulder pain. MTUS guidelines for shoulder surgery not met. There is no documentation of full thickness rotator cuff tear. There is no documentation of significant loss of motion. There are no red flags for shoulder surgery such as fracture or tumor. Surgery is not more effective than conservative measures.

#### **Pre-operative clearance: 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:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

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

#### **Polar care x 21 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

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

#### **Augmentin: 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:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 209.

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