

<b>Case Number:</b>	CM15-0010556		
<b>Date Assigned:</b>	01/28/2015	<b>Date of Injury:</b>	07/26/2005
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	01/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/19/2015

### 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

Certification(s)/Specialty: Neurological 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:

This 59 year old male maintenance man on August 26, 2005 fell 5 feet off ground from ladder striking his left arm on the ladder leg as lower extremity caught on the ladder. A diagnosis of a ruptured biceps tendon was made and repaired on 02/17/06. Electrical studies suggested a brachial plexopathy. An MRI of his left shoulder on 10/18/05 suggested moderate left impingement. He went thru pain management and on 09/25/2013 a C3-7 partial corpectomy and anterior cervical fusion from C3-7 was performed. He subsequently reported right shoulder pain. A MRI of his right shoulder 12/5/2013 showed a partial thickness tear of his supraspinatus with no evidence of tendon retraction. Degenerative changes in the AC joint were noted as well as spur formation on the undersurface of the acromion. He was diagnosed with right shoulder rotator cuff tear, and right shoulder impingement. Treatment to date has included diagnostic studies, radiographic imaging, surgical consultation, surgical intervention as above, pain medications, Norco 10/325 q 4 hours, Soma 350mg qid, Nucynta 100mg and activity adjustments. Currently, the IW complains of continued right shoulder pain, neck pain which radiates down right upper extremity and low back pain. On January 8, 2015, Utilization Review non-certified a right shoulder arthroscopic procedures, Norco 10/325, a cold therapy unit, post-operative labs, pre-operative urinalysis and surgical clearance, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On January 16, 2015, the injured worker submitted an application for IMR for review of requested right shoulder arthroscopic procedures, Norco 10/325, a cold therapy unit, post-operative labs, pre-operative urinalysis and surgical clearance.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder:**  
Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter-Surgery for impingement syndrome.

**Decision rationale:** The ODG guidelines in criteria for acromioplasty note that 80% of patients will get better without surgery. The guidelines state acromioplasty is not recommended in conjunction with full thickness rotator cuff repair. They note that conservative care is directed toward gaining a full range of motion. The documentation does not give evidence of a directed physical therapy program toward this end or details of a home exercise program. Documentation from imaging does not show positive evidence of impingement. There is no evidence of the outcome of injections. Thus the criteria from the ODG are not met. The Requested treatment: arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder are not medically necessary and appropriate.

**Pre-operative Labs; CBC, CMP, 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, treatment index, 12th edition (web), 2014, Low Back, preoperative lab testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the Requested treatment: arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder is not medically necessary and appropriate, then the Requested Treatment: Pre-operative Labs; CBC, CMP, PT, PTT is not medically necessary and appropriate.

**Decision rationale:** Since the Requested treatment: arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder is not medically necessary and appropriate, then the Requested Treatment: Pre-operative Labs; CBC, CMP, PT, PTT is not medically necessary and appropriate.

**Post-Operative DME; Cold Therapy Unit-no duration give:** 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, Continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Requested treatment: arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder is not medically necessary and appropriate, then the Requested Treatment: Post-operative DME; cold therapy unit-no duration given is not medically necessary and appropriate.

**Decision rationale:** Since the Requested treatment: arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder is not medically necessary and appropriate, then the Requested Treatment: Post-operative DME; cold therapy unit-no duration given is not medically necessary and appropriate.

**Norco 10/325mg, quantity unknown:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 34.

**MAXIMUS guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Opioids for neuropathic pain; On-going management Page(s): 82, 78.

**Decision rationale:** The California MTUS guidelines state that opioids should be given in the lowest possible dose to improve pain and function. Therefore the documentation should show ongoing review, functional status, appropriate medication use and side effects. Documentation does not do this. The requested treatment does not include a quantity. The requested treatment does not include a frequency. Documentation does not cover the 4A's for ongoing monitoring. Thus the requested treatment Norco10/325mg, quantity unknown is not medically necessary and appropriate.

**Surgical 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, treatment index, 12th edition (web), 2014, Low Back, preoperative testing general.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the Requested treatment: arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder is not medically necessary and appropriate then the requested treatment: surgical clearance is not medically necessary and appropriate.

**Decision rationale:** Since the Requested treatment: arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder is not medically necessary and appropriate then the requested treatment: surgical clearance is not medically necessary and appropriate.

**Pre-operative Urine analysis:** 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, preoperative lab testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the Requested treatment: arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder is not medically necessary and appropriate then the requested treatment: pre-operative urine analysis is not medically necessary and appropriate.

**Decision rationale:** Since the Requested treatment: arthroscopic subacromial decompression, rotator cuff repair and possible biceps tenodesis, Mumford procedure, glenohumeral joint debridement and synovectomy of right shoulder is not medically necessary and appropriate then the requested treatment: pre-operative urine analysis is not medically necessary and appropriate.