

<b>Case Number:</b>	CM15-0136102		
<b>Date Assigned:</b>	07/31/2015	<b>Date of Injury:</b>	10/02/2014
<b>Decision Date:</b>	10/02/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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: California, Oregon, 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 57-year-old male, who sustained an industrial injury on October 02, 2014. The injured worker reported that during a power outage at work, the injured worker had to walk in his work place causing him to fall where he sustained an injury to his shoulder. The injured worker was diagnosed as having rule out right shoulder rotator cuff tear and impingement, right shoulder impending adhesive capsulitis, cervical strain and sprain, thoracic strain and sprain, lumbar strain and sprain, and bilateral knee contusions. Treatment and diagnostic studies to date has included physical therapy, laboratory studies, magnetic resonance imaging of the right shoulder, medication regimen, and injection into the subacromial space. In a progress note dated June 01, 2015 the treating physician reports complaints of an increase in pain to the right shoulder along with complaints of pain to the cervical spine, thoracic spine, and the low back. Examination reveals tenderness to the right shoulder, positive impingement testing to the right shoulder, atrophy to the right deltoid muscles, positive Jobe testing, and decreased range of motion to the right shoulder. The injured worker's pain to the right shoulder was rated a 9 out of 10. The treating physician noted injection to the subacromial space decreased the injured worker's pain on temporary basis. The medical records provided noted magnetic resonance imaging of the right shoulder performed on February 10, 2015 that was revealing for partial synovial surface tear involving the infraspinatus tendon, tendinopathy of the supraspinatus and infraspinatus tendons with possible partial tears involving the bursal surfaces, Type III acromion process with prominent lateral down sloping place, and finding of non-displaced tear of the superior labrum. The treating physician requested right arthroscopic subacromial decompression

and debridement of rotator cuff with anesthesia with a medical doctor noting failed conservative treatments. The treating physician also requested pre-operative evaluation with complete blood count with differential, urinalysis, comprehensive metabolic panel, prothrombin time, partial thromboplastin time, electrocardiogram, and pre-operative history and physical along with post-operative treatment of physical therapy three times four and Anaprox 550mg with a quantity of 60, but the documentation provided did not indicate the specific reasons for the requested treatments, studies, and evaluation.

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

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

#### **Right Arthroscopic subacromial decompression and debridement of rotator cuff with anesthesia by MD: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, (Online Version), surgery for impingement syndrome.

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

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 6/1/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case, the exam note from 6/1/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the request is not medically necessary.

#### **Pre-op Labs: CBC w/diff: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI), preoperative evaluation, 2008 Jul, page 32.

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

#### **Pre-op Labs: UA: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement

(ICSI), preoperative evaluation, 2008 Jul, page 32.

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Pre-op Labs: Chem Panel (CMP): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI), preoperative evaluation, 2008 Jul, page 32.

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Pre-op Labs: PT/PTT: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI), preoperative evaluation, 2008 Jul, page 32.

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Post-operative Physical Therapy 3 x 4: Upheld**

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

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Post-operative Anaprox 550mg, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen; NSAIDs, specific drug list & adverse effects - Naproxen (Naprosyn).

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Pre-operative EKG: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI), preoperative evaluation, 2008 July, page 32.

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Pre-operative History and Physical: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI), preoperative evaluation, 2008 July, page 32.

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.