

<b>Case Number:</b>	CM15-0138431		
<b>Date Assigned:</b>	07/31/2015	<b>Date of Injury:</b>	04/07/2014
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	06/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2015

### 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, Indiana, Oregon  
 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 male, who sustained an industrial injury on 4-7-14. He reported right wrist, hand, arm and forehead injury following a fall from a ladder. The injured worker was diagnosed as having right shoulder strain, right shoulder impingement and right shoulder partial rotator cuff tear. Treatment to date has included right wrist and elbow surgery, physical therapy, acupuncture, anti-inflammatories, home exercise program, steroid injection and activity restrictions. (MRI) magnetic resonance imaging of lumbar spine performed on 7-10-14 revealed desiccated disc at T12-L1, L3-4 disc desiccation and degeneration, 3mm broad based disc bulge at L4-5 and L5-S1 disc desiccation. (MRI) magnetic resonance imaging of cervical spine performed on 7-9-14 revealed disc desiccation at C2-3, C3-4, C4-5, C5-6, C6-7 and C7-T1 along with disc protrusion at C7-T1, C2-3, C3-5 and C4-5. (EMG) Electromyogram studies performed on 7-28-14 revealed no abnormalities. (MRI) magnetic resonance imaging of right shoulder performed on 3-31-15 revealed acromioclavicular osteoarthritis, subchondral cyst formation in humeral head, glenohumeral osteoarthritis, supraspinatus tendinosis and infraspinatus tendinosis. Currently on 6-10-15, the injured worker complains of significant pain in right shoulder, especially at night, reaching overhead and with lifting and going through an arc of range of motion. He is currently on temporary total disability. Physical exam performed on 6-10-15 revealed restricted range of motion of right shoulder with impingement. The treatment plan included a right shoulder arthroscopy with subacromial decompression. A request for authorization was submitted on 6-17-15 for right shoulder arthroscopy with subacromial decompression, debridement versus repair of rotator cuff, possible biceps tenotomy and possible distal clavicle resection, pre-operative medical clearance, blood work, chest x-rays and EKG, abduction pillow and polar care unit rental for post-op use.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopy with subacromial decompression, debridement vs. repair of rotator cuff, possible biceps tenotomy and possible distal clavicle resection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for surgery.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition, the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally, there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case, the MRI does not demonstrate a rotator cuff tear. The request is not medically necessary.

**Pre-op medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Pre-op CBC:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

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

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Pre-op Electrolytes:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Pre-op Creatine and Glucose:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Pre-op chest x-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Pre-op electrocardiogram:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 with abduction pillow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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: Polar care unit x 3 week rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Post-op physical therapy, unknown sessions:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Post-op unknown pain medications:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.