MAXIMUS Federal Services

| Case Number: | CM15-0139335 | | |
|---|---|---|---|
| Date Assigned: | 08/03/2015 | Date of Injury: | 09/28/2014 |
| Decision Date: | 09/03/2015 | UR Denial Date: | 06/30/2015 |
| Priority: | Standard | Application Received: | 07/17/2015 |

## 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:

This 41 year old male sustained an industrial injury to the right shoulder on 9-25-14. X-rays of the right shoulder on 10-21-14 showed no bony abnormalities. Magnetic resonance imaging right shoulder (12-8-14) showed inflammatory arthrosis of the right acromial joint and moderate rotator cuff tendinosis and a bursal surface tear of the supraspinatus tendon. Previous treatment included physical therapy, injections, home exercise and medications. In a PR-2 dated 6-8/15, the injured worker complained of continuing right shoulder pain associated with sharp pain with reaching activities. Physical exam was remarkable for right shoulder with positive biceps supination test, impingement tests and post subluxation test, tenderness to palpation to the acromioclavicular joint and biceps tendon with decreased range of motion. Current diagnoses included possible superior labral anterior posterior tear, impingement, possible biceps tear and acromioclavicular joint synovitis. The treatment plan included continuing home exercise, icing and anti-inflammatory medications. On 6-23-15, a request for authorization was submitted for examination of right shoulder under anesthesia with right shoulder arthroscopy with possible subacromial decompression, biceps tenodesis, resection of the distal clavicle and labral repair with associated surgical services.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Examination of right shoulder under anesthesia:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Tanaka, Makoto, et al. "Evaluation of dislocation position in patients with recurrent anterior shoulder dislocation." Journal of Shoulder and Elbow Surgery 21.11 (2012): 1588-1592.

**Decision rationale:** CA MTUS/ACOEM and ODG are silent on examination under anesthesia for the shoulder. Alternative reference is used. Recent peer-reviewed literature highlights the utility of examination under anesthesia only for patients with instability of the shoulder. In this case, the history and physical examination are not demonstrative of instability and no examination under anesthesia to further evaluate this is warranted. The request is not medically necessary.

**Right shoulder arthroscopy with possible subacromial decompression, biceps tenodesis, resection of the distal clavicle and labral repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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:** 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. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. In this case there is insufficient evidence to warrant labral repair secondary to lack of physical examination findings, lack of documentation of conservative care or characterization of the type of labral tear. Therefore request is not medically necessary.

**Associated surgical service: Assistant surgeon:** 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 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.

**Post-op physical therapy Quantity: 12:** 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: Ultrasling:** 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: Contrast compression unit/Thermacare (days) Quantity: 7:** 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: Pad (Indefinite use):** 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.