

<b>Case Number:</b>	CM15-0163454		
<b>Date Assigned:</b>	09/01/2015	<b>Date of Injury:</b>	01/02/2008
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	07/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2015

### 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 65-year-old male, who sustained an industrial injury on 1-2-08. The diagnoses have included lumbar disc disease, lumbar radiculopathy, probable cervical spine disc rupture, probable left shoulder internal derangement, left elbow strain, left hip strain, status post left knee surgery 11-18-10, left ankle internal derangement, right shoulder tendinosis and right elbow strain. Treatment to date has included medications, activity modifications, diagnostics, shoulder injection, and other modalities. Currently, as per the physician progress note dated 7-14-15, the injured worker complains of neck pain, low back pain, left hip pain, right shoulder pain and right elbow pain. The physician notes that the injured worker had a lumbar epidural steroid injection (ESI) in 9-2014 and he had first cortisone injection to the right shoulder on 4-4-15 and second injection is scheduled for 11-2-15. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the right shoulder. There was also Magnetic Resonance Imaging (MRI) of the lumbar spine, left shoulder and left ankle that were noted to be performed. The diagnostic reports were not noted in the records. The objective findings-physical exam reveals that the light touch sensation to the left mid anterior thigh, left mid lateral calf and left lateral ankle are intact. There are no other significant findings noted. The physician requested treatments included Right shoulder arthroscopy, Left shoulder arthroscopy, Right ankle arthroscopy, Left ankle arthroscopy, Right knee arthroscopy, Shockwave therapy for the right shoulder, quantity: 6 sessions, and Aqua therapy for the lumbar spine and left hip, quantity: 6 sessions.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Right shoulder arthroscopy:** Upheld

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

**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, page 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. 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 notes do not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Finally, the MRI from 1/12/11 failed to show the existence of a surgical lesion. Therefore, the determination is not medically necessary.

### **Left shoulder arthroscopy:** Upheld

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

**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, page 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. 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 notes do not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Finally, the MRI from 1/12/11 failed to show the existence of a surgical lesion. Therefore, the determination is not medically necessary.

### **Right ankle arthroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-375.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Ankle and Foot criteria.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of ankle arthroscopy. Per the ODG Ankle and Foot criteria, "Ankle arthroscopy for ankle instability, septic arthritis, arthrofibrosis, and removal of loose bodies is supported with only poor-quality evidence. Except for arthrodesis, treatment of ankle arthritis, excluding isolated bony impingement, is not effective and therefore this indication is not recommended. Finally, there is insufficient evidence-based literature to support or refute the benefit of arthroscopy for the treatment of synovitis and fractures." In this case there is no evidence in the cited records from 7/14/15 of significant pathology to warrant surgical care. There is no MRI of the right ankle that shows a surgical lesion. Therefore, the determination is not medically necessary.

**Left ankle arthroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-375.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Ankle and Foot criteria.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of ankle arthroscopy. Per the ODG Ankle and Foot criteria, "Ankle arthroscopy for ankle instability, septic arthritis, arthrofibrosis, and removal of loose bodies is supported with only poor-quality evidence. Except for arthrodesis, treatment of ankle arthritis, excluding isolated bony impingement, is not effective and therefore this indication is not recommended. Finally, there is insufficient evidence-based literature to support or refute the benefit of arthroscopy for the treatment of synovitis and fractures." In this case, there is no evidence in the cited records from 7/14/15 of significant pathology to warrant surgical care. Additionally the MRI of the right ankle from 1/13/11 was normal. Therefore, the determination is not medically necessary.

**Right knee arthroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 345.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345.

**Decision rationale:** CA-MTUS/ACOEM Chapter 13 Knee Complaints, pages 344-345, states regarding meniscus tears, "Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear symptoms other than simply pain (locking, popping, giving way, recurrent effusion)According to ODG Knee and Leg section, Meniscectomy section, states indications for arthroscopy and meniscectomy include attempt at physical therapy and subjective clinical findings, which correlate with objective examination and MRI. In this case, the exam notes from 7/14/15 do not demonstrate evidence of adequate course

of physical therapy or other conservative measures. In addition, there is lack of evidence in the cited records of meniscal symptoms such as locking, popping, giving way or recurrent effusion. Therefore, the determination is for non-certification. CA-MTUS/ACOEM Chapter 13 Knee Complaints, pages 344-345, states regarding meniscus tears, "Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear symptoms other than simply pain (locking, popping, giving way, recurrent effusion); clear signs of a bucket handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion); and consistent findings on MRI." In this case, the MRI from 6/6/11 demonstrates osteoarthritis of the knee without clear evidence of meniscus tear. The ACOEM guidelines state that, "Arthroscopy and meniscus surgery may not be equally beneficial for those patients who are exhibiting signs of degenerative changes." According to ODG, Knee and Leg Chapter, Arthroscopic Surgery for osteoarthritis, "Not recommended. Arthroscopic lavage and debridement in patients with osteoarthritis of the knee is no better than placebo surgery, and arthroscopic surgery provides no additional benefit compared to optimized physical and medical therapy." As the patient has significant osteoarthritis, the request is not medically necessary.

**Shockwave therapy, quantity: 6 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shockwave therapy for the knee. Per the ODG criteria cited above, ESWT is under study for patellar tendinopathy and for long bone hypertrophic nonunion. It is not recommended by the ODG and therefore determination is not medically necessary.

**Aqua therapy, quantity: 6 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chapter 9 Shoulder Complaints.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services is 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.