

<b>Case Number:</b>	CM15-0054170		
<b>Date Assigned:</b>	04/16/2015	<b>Date of Injury:</b>	02/28/2014
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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: Illinois, California, Texas  
 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 35-year-old female who sustained an industrial injury on 2/28/14. Injury was reported relative to repetitive typing and office work. Past medical history was positive for hypertension and occasional smoking. The 4/29/14 left shoulder MRI impression documented mild rotator cuff tendinosis. Findings documented acromioclavicular (AC) joint was intact with mild capsular thickening. The distal acromial epiphysis was fused and demonstrated a minimal gentle curved undersurface. Conservative treatment included medication regimen, acupuncture, chiropractic therapy, and physical therapy without sustained improvement. The 2/9/15 treating physician report cited on-going left shoulder and neck pain with associated tingling, burning, popping, stiffness, stabbing, weakness, numbness and tenderness. She also reported left neck pain radiating to the left upper extremity in a C8 distribution with numbness and paresthesias radiating to her left hand ulnar digits. Pain was 8-10/10, and worsened with repetitive use and prolonged sitting. She had a left shoulder injection 2 weeks ago with partial relief. Cervical exam documented limited rotation with pain, and positive Spurling's sign with normal sensation and reflexes. Left shoulder exam documented positive impingement and supraspinatus signs, acromioclavicular joint tenderness, and crepitus. Left shoulder range of motion was limited to 120 degrees flexion and 110 degrees abduction. There was imaging evidence of rotator cuff tendinosis. On 2/25/15, the treating physician requested left shoulder arthroscopic decompression with possible repair as needed, pre-operative medical clearance to including chest x-ray, EKG, complete blood count (CBC), comprehensive metabolic panel (CMP), urinalysis (UA), prothrombin time, partial thromboplastin time (PT/PTT), thyroid stimulating hormone (TSH),

and cold therapy unit. The 3/3/15 utilization review modified a request for right shoulder arthroscopy decompression with possible repair to left shoulder arthroscopic subacromial decompression. The request for possible repair was non-certified as there was no evidence of a full thickness rotator cuff tear that would require repair. The request for pre-operative medical clearance to include chest x-ray, EKG, CBC, CMP, UA, PT/PTT, and TSH was modified to pre-operative medical clearance to include pre-operative medical clearance to include chest x-ray, EKG, CBC, CMP, UA, and PT/PTT. The request for TSH was not supported as the injured worker had no history of endocrine or thyroid disorders. The request for cold therapy unit was modified to allow for post-op cold therapy unit for a 7-day rental consistent with the Official Disability Guidelines.

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

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

**Left Shoulder Arthroscopic Subacromial Decompression with possible repair as needed:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for impingement syndrome; Surgery for rotator cuff repair.

**Decision rationale:** The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific surgical indications for impingement syndrome and partial rotator cuff tears that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Conventional x-rays, AP, and true lateral or axillary view. AND MRI, ultrasound, or arthrogram showing positive evidence of impingement are required. Guideline criteria have been met. This injured worker presents with persistent right shoulder pain and limited function. Clinical exam findings are consistent with imaging evidence of rotator cuff pathology and plausible impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The 3/3/15 utilization review modified this request to allow for subacromial decompression, rotator cuff repair was not certified. There is imaging evidence of rotator cuff tendinosis. It is reasonable to allow for possible rotator cuff repair at the discretion of the operating surgeon if a tear is found at the time of arthroscopic surgery. Therefore, this request is medically necessary.

**Pre-operative medical clearance to include CXR, EKG, CBC, CMP, UA, PT/PTT, TSH:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter-Pre operative EKG and Lab testing).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3): 522-38.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. The 3/3/15 utilization review modified this request to include pre-operative medical clearance to include chest x-ray, EKG, CBC, CMP, UA, and PT/PTT. There is no compelling rationale to support the medical necessity of lab assessment of thyroid function. Review of systems documented that there were no endocrine or thyroid disorders. Therefore, this request is not medically necessary.

**Associated Surgical Services: Cold Therapy Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee Chapter-Continuous-flow cryotherapy.

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

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 3/3/15 utilization review decision recommended partial certification of this cold therapy device for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.