

<b>Case Number:</b>	CM15-0056804		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	09/24/2014
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	02/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2015

### 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

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 60 year old male, who sustained a work/industrial injury on 9/24/14. The injury reportedly occurred when he was pulling on a device to separate a tire and felt pain. He has reported initial symptoms of shoulder and wrist pain. The injured worker was diagnosed as having post traumatic bursitis, impingement, type II acromion morphology and acromio-clavicular joint degeneration and left volar ganglion cyst. Treatments to date included medications, diagnostics, modified activity, physical therapy, and acupuncture. Magnetic Resonance Imaging (MRI) was performed on 12/3/14. Currently, the injured worker complains of continued left shoulder pain and weakness. The orthopedic physician's report from 2/11/15 indicated evaluation was for left shoulder and left wrist ganglion cyst. Pain was rated 5/10. Examination revealed normal cervical spine range of motion, shoulder range of motion was normal bilaterally, motor strength was normal bilaterally. There was a positive Neer impingement sign, positive Hawkins impingement sign and positive O'Brian's test. Magnetic Resonance Imaging (MRI) report confirmed supraspinatus tendinitis, infraspinatus tendinitis, acromioclavicular joint arthritis, and type II acromion morphology with downsloping and an impingement. Treatment plan included Left Shoulder Diagnostic/Operative Arthroscopic Debridement, with acromioplasty resection of coracoacromial ligament and bursa, and possible distal clavicle resection, Post-Operative Physical Therapy, Post-Operative Sling, and Medical Clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Diagnostic/Operative Arthroscopic Debridement, with acromioplasty resection of coracoacromial ligament and bursa, 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: Shoulder (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 211.

**Decision rationale:** The request for Left Shoulder Diagnostic/Operative Arthroscopic Debridement, with acromioplasty resection of coracoacromial ligament and bursa, and possible distal clavicle resection is not medically necessary. The injured worker continued to complain of pain. The California MTUS/ACOEM Guidelines recommend arthroscopic decompression for impingement syndrome but not for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. The injured worker had a documented significant increase in function and decrease in pain following physical therapy. Physical examination by the treating clinician indicated full range of motion with full strength and no tenderness to palpation. There was no documentation of pain with motion or of nighttime shoulder pain. As such, the requested service is not supported. Therefore, the request for Left Shoulder Diagnostic/ Operative Arthroscopic Debridement, with acromioplasty resection of coracoacromial ligament and bursa, and possible distal clavicle resection is not medically necessary.

**Post-Operative Physical Therapy, 12 Sessions:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** The request for postoperative physical therapy, 12 sessions, is not medically necessary. The concurrent request for surgical intervention was found to be not medically necessary. While the California Postsurgical Medical Treatment Guidelines would support an initial course of physical therapy in the amount of 12 sessions following surgical intervention for impingement syndrome, the concurrent request for the surgical intervention was not supported. Therefore, the request for postoperative physical therapy, 12 sessions, is not medically necessary.

**Post-Operative Sling:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Postoperative abduction pillow sling.

**Decision rationale:** The request for postoperative sling is not medically necessary. The concurrent request for surgical intervention was found to be not medically necessary. The Official Disability Guidelines recommend postoperative abduction pillow slings as an option following open repair of large and massive rotator cuff tears. The requested procedure was an arthroscopic procedure and, were the procedure medically necessary, the postoperative abduction pillow sling would not be supported as there was no documentation of a large or massive rotator cuff tear. Therefore, the request for postoperative sling is not medically necessary.

**Medical Clearance - CBC (complete blood count), CMP (comprehensive metabolic panel), HEP (hepatitis) panel, HIV panel, U/A (urinalysis), EKG (electrocardiogram), Chest Xray:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Preoperative testing, general.

**Decision rationale:** The request for Medical Clearance - CBC (complete blood count), CMP (comprehensive metabolic panel), HEP (hepatitis) panel, HIV panel, U/A (urinalysis), EKG (electrocardiogram), Chest X-ray is not medically necessary. The concurrent request for a surgical procedure was found to not be medically necessary. The Official Disability Guidelines recommend a history and physical with selective testing based on the clinician's findings. A CBC would not be indicated as the injured worker does not have a diagnosis of anemia and significant perioperative blood loss would not be anticipated for the requested procedure. Electrolyte and creatinine testing would only be supported if the injured worker was known to have a chronic disease or was known to take medications that predisposed him to electrolyte abnormalities or renal failure. Random glucose testing would be supported if the injured worker was at high risk of undiagnosed diabetes mellitus. Hepatitis and HIV panels would not be indicated. The requested procedure is not an invasive urologic procedure and there was no indication that implantation of a foreign material was part of the requested surgical procedure. As such, urinalysis would not be supported. Arthroscopic procedures are considered to be low risk and electrocardiograms are not indicated for low risk procedures. A chest x-ray would not be supported without exceptional factors being documented in the preoperative history and physical. As the concurrent request for surgical intervention is not supported, the requested service is not supported. Therefore, the request for Medical Clearance - CBC (complete blood count), CMP (comprehensive metabolic panel), HEP (hepatitis) panel, HIV panel, U/A (urinalysis), EKG (electrocardiogram), Chest X-ray is not medically necessary.

