

<b>Case Number:</b>	CM15-0079195		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	02/13/2007
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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: New York

Certification(s)/Specialty: Neurological 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 58 year old female, who sustained an industrial injury on 2/13/07. Initial complains are not noted. The injured worker was diagnosed as having cervical spine sprain/strain; right shoulder mild acromioclavicular osteoarthritis; right elbow sprain/strain; lumbar spondylosis, spondylolisthesis; right hip contusion; right knee degenerative arthritis, femoropatellar chondromalacia bursitis. Treatment to date has included status post right shoulder arthroscopic subacromial decompression (2/16/09); status post right shoulder arthroscopic surgery (6/30/14); status post right wrist carpal tunnel release (5/19/08); physical therapy; acupuncture; lumbar epidural steroid injections (6/27/14); medications. Diagnostics included MRI right shoulder (12/2/13 and 1/28/15); MRI right knee (9/23/10); MRI lumbar spine (9/23/10 and 11/24/14). Currently, the PR-2 notes dated 3/5/15 indicated the injured worker complains of neck pain with limited range of motion and pain increases with movement. She complains of constant right shoulder pain with pain on movement that radiates to the neck. She is in constant low back pain that radiates to the bilateral legs with numbness and tingling and limited range of motion. A physical examination of the cervical spine demonstrates tenderness to palpation over the trapezius and levator aspect and pain on flexion and extension. The right shoulder shows tenderness to palpitation over the lateral, anterior and superior aspects with positive Neer's, Hawkin's and Jobe's testing. The lumbar examination demonstrates tenderness to palpitation over the lumbar spine junction midline with bilateral hamstring tightness. The provider reviewed the MRI right shoulder completed on 1/28/15 and documents there is a "re-tear" of the tendon although the sutures for the repair are intact. He goes on to states that this is why she is not

progressing clinically as she should be. Therefore, he is requesting: a right shoulder rotator cuff repair revision surgery; Pre-operative CBC with diff, comprehensive metabolic panel with EGFR, PT with INR, PTT activated, TSH, urinalysis; Cold therapy unity (10 days); Post-operative right shoulder sling 1; Post-operative right shoulder physical therapy 12 sessions and Celebrex 200mg #30.

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

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

**Celebrex 200mg Qty: 30.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk, specific drug list Selective Cox-2 Page(s): 68, 70.

**Decision rationale:** The California MTUS guidelines recommend a Cox-2 selective agent such as Celebrex if the patient is at intermediate risk for gastrointestinal events and no cardiovascular disease. If the patient has no risk factors and no cardiovascular disease then a non-selective NSAID is appropriate. Documentation does not show the presence of risk factors. Therefore, the request for Celebrex 200mg qty: 30.00 is not medically necessary and appropriate.

**Right shoulder rotator cuff repair revision surgery: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter-Surgery for rotator cuff repair-revision.

**Decision rationale:** The ODG guidelines indicate the results of revision rotator cuff repair are inferior to those of primary repair. The documentation shows the sutures from the primary operation are intact but the provider is still recommending surgery. The ODG guidelines recommend surgical consultation when there is the existence of a surgical lesion and a failure of exercise programs to increase range of motion and strength. Such evidence is not provided. Therefore, the request for right shoulder rotator cuff repair revision surgery is not medically necessary and appropriate.

**Cold therapy unity (days) Qty: 10.00: 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-operative right shoulder physical therapy Qty: 12.00: 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-operative right shoulder sling Qty: 1.00: 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-operative CBC with diff Qty: 1.00: 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-operative comprehensive metabolic panel with EGFR Qty: 1.00: 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-operative PT with INR Qty: 1.00: 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-operative PTT, activated Qty: 1.00:** 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-operative TSH Qty: 1.00:** 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-operative Urinalysis Qty: 1.00:** 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.