MAXIMUS Federal Services

| Case Number: | CM14-0152747 | | |
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| Date Assigned: | 09/23/2014 | Date of Injury: | 02/22/2010 |
| Decision Date: | 11/21/2014 | UR Denial Date: | 09/11/2014 |
| Priority: | Standard | Application Received: | 09/18/2014 |

## 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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

## 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 51-year-old female janitor sustained an industrial injury on 2/22/10. Injury occurred while cleaning offices and picking up trash. The patient underwent right shoulder arthroscopy with rotator cuff repair, biceps tenodesis, Mumford procedure, lysis of adhesions with subacromial bursectomy, partial synovectomy, and removal of loose bodies on 4/9/13. The 7/21/14 treating chiropractor report cited right shoulder pain not relieved with home therapy and exercise. Right shoulder exam documented tenderness and spasms over the rotator cuff muscles and acromioclavicular joint. Range of motion testing documented flexion 118, extension 40, abduction 130, adduction 40, and internal/external rotation 70 degrees. The patient had positive apprehension test and impingement sign. The patient had completed acupuncture and physical therapy treatments. The 7/31/14 right shoulder MRI impression documented postsurgical changes of the rotator cuff. There were findings consistent with a high-grade partial thickness bursal side tear versus small full thickness tear close to the musculotendinous junction of the supraspinatus tendon. There was no retraction of the musculotendinous junction or muscle atrophy. The acromion was slightly laterally downsloping and Type 1 with slight increased risk of impingement. The 8/25/14 treating physician report cited continued right shoulder pain and weakness. Physical exam documented marked external rotation weakness with positive impingement sign. Surgical intervention was recommended. The 9/11/14 utilization review denied the right shoulder surgery and associated requests as there was no evidence of conservative treatment, including physical therapy and corticosteroid injections.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Diagnostic Arthroscopy with Small Rotator Cuff Repair:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers' Compensation, Online edition, Shoulder Chapter, Diagnostic Arthroscopy and ODG Indications for Surgery, Rotator Cuff Repair

**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 Rotator Cuff Repair; Surgery for Impingement Syndrome

**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. The Official Disability Guidelines provide more specific indications for impingement syndrome 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. Guidelines for rotator cuff repair of partial thickness tears require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement or rotator cuff deficit are required. Guideline criteria have not been met. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including corticosteroid injection, and failure has not been submitted. There is no evidence of a positive diagnostic injection test. Therefore, this request is not medically necessary.

**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.

**Preoperative Medical Clearance with Physical Examination:** 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.

**12 Postoperative Physical Therapy Sessions:** 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.

**One (1) Urinalysis:** 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.

**Preoperative Chest X-Ray:** 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.

**Preoperative Labs: Complete Blood Count, Comprehensive Metabolic Panel, Prothrombin and Partial Thromboplastin Time Tests:** 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.

**Preoperative Electrocardiography:** 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.

**One (1) Shoulder Sling for Purchase:** 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.

**One (1) Pain Pump for Purchase:** 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.

**One (1) Cold Therapy Unit for Purchase:** 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.