

<b>Case Number:</b>	CM15-0011348		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	09/01/2013
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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: 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 38-year-old female, who sustained an industrial injury on 9/1/13 due to repetitive work duties as a janitor. The 1/3/14 bilateral shoulder ultrasound was reported normal. The 1/14/14 right shoulder MRI impression documented mild to moderate subacromial/subdeltoid bursitis without evidence of rotator cuff tear. The 1/27/14 electrodiagnostic study findings were consistent with mild to moderate carpal tunnel syndrome. The 2/8/14 cervical MRI documented a C5/6/6 disc bulge. The 6/10/14 treating physician report cited right shoulder pain and range of motion improving with physical therapy. Therapeutic exercises and medications were helping. There were continued cervicothoracic symptoms extending into the right shoulder blade. Cervical medial branch blocks were provided on 7/9/14. The 10/9/14 treating physician report cited neck pain extending into the upper back and down the left arm to the hand. Right shoulder pain was better. Chiropractic treatment was continuing. The 12/3/14 orthopedic report cited continued right shoulder pain, limited with daily activities. Right shoulder exam documented range of motion limited to 140 degrees of flexion and abduction, and extension limited to 30 degrees, with positive Hawkin's test. Upper extremity muscle strength was 5/5. A right shoulder corticosteroid injection was performed. The 12/17/14 treating physician report cited pain in the left shoulder and minimal improvement with shoulder injection. Left shoulder exam documented range of motion limited to 140 degrees of flexion and abduction, and extension limited to 30 degrees, with positive Hawkin's test on the right. Upper extremity muscle strength was 5/5. The diagnosis was bilateral shoulder tendonitis and improvement. The treating physician indicated that the injured worker had tried and failed

conservative therapy, including physical therapy and medications. The treating physician requested a left shoulder arthroscopy and decompression, and associated pre-operative evaluation and testing. On 1/2/15 Utilization Review non-certified a request for a left shoulder arthroscopy and decompression, a pre-operative evaluation, EKG, urine screen, chest x-ray, PT/PTT, CBC and CMP. The utilization review physician cited the MTUS and ODG guidelines for surgery for impingement syndrome. The rationale for non-certification cited a lack of left shoulder imaging documentation, and no clear clinical or diagnostic evidence of impingement. On 1/20/15, the injured worker submitted an IMR application.

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

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

#### **Left shoulder arthroscopy and decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): (s) 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Surgery for impingement syndrome, Low back chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Shoulder: 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. Guidelines indications include clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty 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. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. This patient presents with a reported left shoulder pain complaint limiting activities of daily living. All prior treatment appears focused on the right shoulder, including the recent corticosteroid injection. The diagnosis included bilateral tendinitis and impingement. There is no imaging evidence of left shoulder impingement. Detailed evidence of 3 to 6 month(s) of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the left shoulder and failure has not been submitted. Therefore, this request is not medically necessary.

#### **Pre-op 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.

**Associated surgical service: EKG:** 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.

**Associated surgical service: 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.

**Associated surgical service: 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.

**Associated surgical service: Prothrombin time (PT):** 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.

**Associated surgical service: Partial prothrombin time (PTT):** 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.

**Associated surgical service: Complete blood count (CBC):** 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.

**Associated surgical service: Comprehensive metabolic panel (CMP):** 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.