

<b>Case Number:</b>	CM15-0124385		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	08/26/2011
<b>Decision Date:</b>	08/13/2015	<b>UR Denial Date:</b>	05/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/29/2015

### 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, Indiana, Oregon  
 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 55 year old female who sustained an industrial injury on 8-26-11 as the result of a motor vehicle accident. In a comprehensive orthopedic second opinion surgical consult report dated 5-15-15, the physician notes she underwent right arthroscopic decompression 2-18-13 and despite surgery and post-operative therapy, has developed ongoing right shoulder pain, tenderness, stiffness and weakness. A repeat MRI scan arthrogram of the right shoulder done 4-8-13 reveals tendinosis of the long head of the biceps, but no rotator cuff tear, type II acromion process, and minimal acromioclavicular degenerative joint disease. A right shoulder MRI scan arthrogram report dated 4-8-15 reveals biceps tendinosis and glenohumeral joint patholaxity. Shoulder range of motion in degrees is right then left; forward flexion 160 and 180, extension 50 and 50, abduction 160 and 180, adduction 50 and 50, external rotation 40 and 90, internal rotation 60 and 90. There is tenderness at the right supraspinatus, greater tuberosity, biceps tendon and subacromial crepitus and is positive for subluxation and laxity. Right shoulder movement is painful and testing is affected by pain. The injured worker is advised she is an excellent candidate for right shoulder surgery. Work status is to continue working without restrictions. The requested treatment is right shoulder arthroscopy, possible arthroscopic versus open decompression with acromioplasty, coracoplasty, labral debridement versus repair, resection of coracoacromial ligament and-or bursa as indicated, distal clavicle resection, biceps tendinosis, pre-operative medical clearance, associated surgical services; toxicology urine testing, post-operative physical therapy 3 times a week for 6 weeks, associated surgical services: cold therapy unit (30 day rental), associated surgical services: E-Stim (14 day rentals), associated

surgical services: sling with large abduction pillow, associated services: continuous passive motion unit (30 days rental), post-operative deep vein thrombosis compression home unit with bilateral calf sleeve (30 day rental), associated surgical services: assistant surgeon.

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

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

**Right shoulder arthroscopy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of diagnostic knee arthroscopy. Per ODG knee, the criteria to consider diagnostic arthroscopy of the shoulder are: 1. Conservative Care (medications or PT) and 2. Subjective clinical findings 3. Imaging findings. In this case, there is no recent imaging demonstrating surgical pathology or equivocal findings. Therefore the request is not medically necessary.

**Possible arthroscopic vs. open decompression with acromioplasty:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 5/15/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the request does not adhere to guideline recommendations and is not medically necessary.

**Coracoplasty:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 5/15/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the request does not adhere to guideline recommendations and is not medically necessary.

**Labral debridement vs repair:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. In this case there is insufficient evidence to warrant labral repair secondary to lack of physical examination findings, lack of documentation of conservative care or characterization of the type of labral tear. Therefore request is not medically necessary.

**Resection of coracoacromial ligament and/or bursa as indicated:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees.

In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 5/15/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the request does not adhere to guideline recommendations and is not medically necessary.

**Distal clavicle resection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** Based upon the CA MTUS Shoulder Chapter, pgs 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case there is no significant AC joint arthrosis to warrant excision. The request is not medically necessary.

**Biceps tenodesis:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of biceps tenodesis. According to the Official Disability Guidelines, Criteria for tenodesis of long head of biceps include subjective clinical findings including objective clinical findings. In addition there should be imaging findings. Criteria for tenodesis of long head of biceps include a diagnosis of complete tear of the proximal biceps tendon. In this case the MRI from does not demonstrate evidence that the biceps tendon is partially torn or frayed to warrant tenodesis. Therefore the request is not medically necessary.

**Pre-op medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Toxicology urine testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-op Physical therapy 3x6:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Cold therapy unit (30 day rental):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: E-stim (14 days rental):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Sling with large abduction pillow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: CPM unit 30 days rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative DVT compression home unit with bilateral calf sleeve (30 day rental):**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.