

Case Number:	CM15-0026260		
Date Assigned:	02/18/2015	Date of Injury:	10/11/2005
Decision Date:	04/01/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	02/11/2015

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 55-year-old male who sustained an industrial injury on 10/11/05, relative to cumulative work trauma. Previous treatment since 2005, included physical therapy, multiple elbow, shoulder and cervical spine injections, and medications. Past medical history was positive for hypertension, hyperlipidemia, and depression, anxiety and nervousness. The 2/2/15 treating physician report cited constant grade 5/10 neck pain with burning pain in the right shoulder, pain in the right elbow, and intermittent numbness in both hands. Current medications included Tramadol, Naproxen, and Pantoprazole. Physical exam documented right shoulder range of motion as flexion 160, abduction 160, external rotation 90, internal rotation 60, extension 40, and adduction 30. There was tenderness to palpation over the right anterior shoulder, greater tuberosity, and acromioclavicular (AC) joint. Impingement test was positive. Right shoulder x-rays were reported unremarkable. MRI findings showed lateral acromial slipping, AC osteoarthritis, supraspinatus and infraspinatus tendinosis, and inferior labral tear. Authorization for right shoulder surgery was pending. On 2/2/15, utilization review non-certified right shoulder arthroscopy, debridement, decompression, possible repair, distal clavicle excision as needed, medical clearance, chest x-ray, EKG, labs, Cold therapy unit and brace and post-op physical therapy 2 times a week for 6 weeks, noting the surgery and all related items are not medically necessary as there is only limited documentation of conservative care for the shoulder issue and no documentation of a subacromial cortisone injection. The MTUS, ACOEM Guidelines, was cited. On 2/11/15, the injured worker submitted an application for IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, debridement, decompression, possible repair, distal clavicle excision as needed: 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), Shoulder, Surgery for impingement syndrome.

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 impingement syndrome; Surgery for rotator cuff repair; Partial claviclectomy.

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. Surgery for impingement syndrome is usually arthroscopic decompression. 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. Conventional x-rays, AP, and true lateral or axillary view. AND MRI, ultrasound, or arthrogram showing positive evidence of impingement are required. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have not been met. The patient presents with moderate right shoulder pain. Clinical exam findings are suggestive of impingement, which would be consistent with the reported MRI findings. X-rays were negative. There is no documentation of strength or evidence of a diagnostic injection test. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including injection, and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Medical clearance: 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

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

Medical clearance: EKG: 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 Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

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

Labs: CBC, CMP, UA, PT/PTT, TSH: 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 Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

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

Post-op DME: cold therapy unit: 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: Continuous flow cryotherapy.

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

Post-op DME: brace: 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-op physical therapy two (2) x six (6): 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.