

<b>Case Number:</b>	CM15-0092643		
<b>Date Assigned:</b>	05/19/2015	<b>Date of Injury:</b>	01/23/2007
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	04/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2015

### 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  
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:

This 54 year old woman sustained an industrial injury on 1/23/2007 after lifting a heavy box. Evaluations include MR arthrogram dated 11/20/2014. Treatment has included oral medications. Physician notes dated 4/1/2015 show complaints of continued right shoulder pain. Recommendations include surgical intervention, anti-inflammatory medication, narcotic medication, antibiotic, anti-emetic medication, stool softener, vitamin C, post-operative physical therapy, assistant surgeon, and pre-operative history and physical.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Pass Labral 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, Surgery of SLAP lesions.

**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, Labral tear surgery.

**Decision rationale:** CA MTUS/ACOEM Shoulder Chapter, pages 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. There is insufficient evidence from the exam note of 4/1/15 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 determination is not medically necessary.

**Possible Rotator Cuff Repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 210.

**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, Surgery for rotator cuff tear.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 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. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 4/1/15 do not demonstrate 4 months of failure of activity modification. The physical exam from 4/1/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is for non-certification for the requested procedure.

**Distal Clavicle Excision:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery.

**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, Partial Claviculectomy.

**Decision rationale:** Based upon the CA MTUS Shoulder Chapter, Pages 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 Claviculectomy, 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 the exam note and the imaging findings from 4/1/15 do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the determination is not medically necessary.

**Debridement: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation ODG shoulder section, acromioplasty surgery.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 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 that is not present in the submitted clinical information from 4/1/15. 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 4/1/15 does not demonstrate evidence satisfying the above criteria. Therefore the determination is not medically necessary.

**Associated surgical service: Assistant Surgeon - Physician's Assistant - Certified: 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) 1. <http://www.aaos.org/about/papers/position/1120.asp>.

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

**Zofran 4mg quantity 10: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ondansetron.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Ondansetron (Zofran).

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

**Vitamin C 500mg quantity 50:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRPS prevention Page(s): 38.

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