

<b>Case Number:</b>	CM13-0066784		
<b>Date Assigned:</b>	04/02/2014	<b>Date of Injury:</b>	12/03/2012
<b>Decision Date:</b>	05/27/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2013

### 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 Orthopedic 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:

The claimant is a 34-year-old gentleman who was injured in a work related accident on 12/03/12. The MRI of 01/08/13 showed supraspinatus tendinosis with a signal change to the fibrocartilage of the labrum for which tearing was not confirmed. There was a grade I acromioclavicular joint separation. Recent clinical records for review included a 07/15/13 progress report indicating left shoulder complaints of pain with no objective findings documented. Recommendation at that time was for a course of physical therapy. Orthopedic reassessment of August 26, 2013 indicated continued complaints of right upper extremity pain and low back pain. Specific to the shoulder there was positive AC joint tenderness, negative Speed's and Yergason and positive Neer impingement testing. The left shoulder was with restricted range of motion to 122 degrees of flexion and 140 degrees of abduction. Based on documentation of failed conservative care, surgery was recommended in the form of subacromial decompression and labral repair. It states the claimant has failed a course of care including corticosteroid injection and therapy as well as medication usage.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **LEFT SHOULDER ARTHROSCOPY: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 21, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery.

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

**Decision rationale:** California ACOEM Guidelines would current not support the role of shoulder arthroscopy. This individual's clinical examination and previous imaging would, at present, not support the role of the surgical process in question. There is no indication of full thickness rotator cuff tearing and no confirmatory imaging findings to support a labral tear or pathology. In absence of the above, the role of surgical arthroscopy in this individual would not be indicated. The request for left shoulder arthroscopy is not medically necessary.

**REPAIR OF SLAP LESION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 21,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery; and Chronic Pain Medical Treatment Guidelines.

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

**Decision rationale:** CA MTUS Guidelines are silent, when looking at Official Disability Guidelines criteria, as stated above, the role of surgery has not been supported. Specifically, the role of a repair of a SLAP lesion is not supported as the claimant's imaging does not confirm the presence of SLAP tear. There is a signal change to the labrum but no further pathology noted. The request for repair of SLAP Lesion is not medically necessary.

**DEBRIDEMENT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 21,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery; and Chronic Pain Medical Treatment Guidelines.

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

**Decision rationale:** California ACOEM Guidelines also would not support the role of debridement as the need for operative intervention has not been established. The request for debridement is not medically necessary.

**POSSIBLE REPAIR OF ROTATOR CUFF:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 21,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208, 210.

**Decision rationale:** California ACOEM Guidelines would not support the role of rotator cuff repair as documentation of full thickness rotator cuff pathology is not indicated by imaging with the claimant's examination showing no indication of weakness. The request for possible repair of rotator cuff is not medically necessary.

**ANTERIOR SUBACROMIAL DECOMPRESSION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 21, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery.

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

**Decision rationale:** California ACOEM Guidelines also would not support the role of subacromial decompression as the need for operative intervention has not been established. The request for Anterior Subacromial Decompression is not medically necessary.

**POSSIBLE MUMFORD PROCEDURE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 21, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery; and Chronic Pain Medical Treatment Guidelines.

**Decision rationale:** CA MTUS Guidelines are silent. When looking at Official Disability Guidelines criteria, a Mumford procedure would not be indicated in this individual who is noted to be with a grade I AC joint separation but does not continue to demonstrate AC joint findings on examination. The request for possible Mumford procedure is not medically necessary.

**POST - OPERATIVE PHYSICAL THERAPY X 12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 21, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** California MTUS Postsurgical Rehabilitative Guidelines would not support the role of physical therapy as the need for operative intervention has not been established. The request for post-operative physical therapy x12 is not medically necessary.

**PRE- OPERATIVE CLEARANCE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 21, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 127.

**Decision rationale:** California ACOEM Guidelines would not support the role of preoperative clearance as the need for operative intervention has not been established. The request for pre-operative clearance is not medically necessary.

**ULTRAM #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids - Tramadol (Ultram) Page(s): 91-94. Decision based on Non-MTUS Citation MTUS: CALIFORNIA MEDICAL TREATMENT UTILIZATION SCHEDULE (MTUS), CHRONIC PAIN / OPIOIDS - TRAMADOL (ULTRAM), 91-94.

**Decision rationale:** CA MTUS Guidelines would not support the role of Ultram. The prescription of Ultram would not be indicated. Guidelines only indicate the role of Ultram as use for short term from acute injuries. There is no indication of use of this agent beyond 16 weeks per guideline criteria. Given the claimant's timeframe from injury, the continued role of Ultram would not be supported. The request for Ultram #60 is not medically necessary.

**SOMA:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Some) Page(s): 65.

**Decision rationale:** California MTUS Guidelines does not support the chronic use of Soma. Soma is indicated only for short term use with reservation. There is at present no indication for continued use of this agent in the chronic setting based on guideline criteria. The request for Soma is not medically necessary.

**DME: SURGICAL STIMULATION RENTAL 9 X 14 DAYS), CONTINUOUS PASSIVE MOTION RENTAL ( X 14 DAYS), COLD THERAPY UNIT RENTAL ( X 15 DAYS), SHOULDER SLING, PAIN PUMP AND Q-TECH RECOVERY SYSTEM: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery; and Chronic Pain Medical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, 555-556.

**Decision rationale:** CA MTUS and Official Disability Guidelines would not support the role of the DME devices in question as the need for operative intervention in this instance has not been supported. The request for DME: Surgical Stimulation Rental 9 X 14 Days), Continuous Passive Motion Rental ( X 14 Days), Cold Therapy Unit Rental ( X 15 Days), Shoulder Sling, Pain Pump And Q-Tech Recovery System is not medically necessary.