

<b>Case Number:</b>	CM13-0053754		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/07/2008
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	11/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2013

### 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 63-year-old female who sustained an injury to the right shoulder on 10/07/08. The medical records provided for review document current complaints of pain with heavy lifting, use of a keyboard, and sleeping. Clinical assessment of 10/28/13 documented that failed conservative care included physical therapy, exercises, and oral medications and specifically states that the claimant had not had prior injections. Radiographs on that date showed a Type II acromion and acromioclavicular joint degenerative change. It was documented that a recent MRI scan showed tendinosis of the supraspinatus and acromioclavicular joint arthritis. The physical examination findings showed full range of motion with no documented weakness but pain at endpoints of abduction and external rotation. There was positive tenderness at the acromioclavicular joint. Surgical intervention was recommended for arthroscopy with subacromial decompression, distal clavicle excision, and possible rotator cuff repair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT SHOULDER ACRIMIOPLASTY, MUMFORD, POSSIBLE ROTATOR CUFF REPAIR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure.

**Decision rationale:** Based on the California ACOEM Guidelines and supported by ODG, the request for right shoulder acromioplasty, Mumford, and possible rotator cuff repair is not recommended as medically necessary. The medical records indicate that the claimant's conservative treatment has not included injection therapy. When looking at surgery for partial thickness rotator cuff tear or impingement, the ACOEM Guidelines recommend up to six months of conservative care including injection therapy before proceeding with operative intervention. Without documentation of prior injection therapy, the requested surgery would not be indicated. Without documentation of need for arthroscopy, there would be no current indication for a Mumford procedure. As such, the request is not medically necessary.

**PREOPERATIVE CBC/CHEM PANEL/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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** The proposed surgery is not recommended as medically necessary. Therefore, the request for preoperative testing is also not medically necessary.

**POSTOPERATIVE PHYSICAL THERAPY TWICE A WEEK FOR SIX WEEKS:** Upheld

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

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

**Decision rationale:** The proposed surgery is not recommended as medically necessary. Therefore, the request for preoperative testing is also not medically necessary.

**COLD THERAPY UNIT:** 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): 201-205, 555-556.

**Decision rationale:** The proposed surgery is not recommended as medically necessary. Therefore, the request for a cryotherapy device is also not medically necessary.

**MOBILIZER PURCHASE:** 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 Treatment in Worker's Comp , 18th Edition, 2013 Updates: shoulder procedure.

**Decision rationale:** The proposed surgery is not medically necessary. Therefore, the request for an immobilizer is also not medically necessary.