

<b>Case Number:</b>	CM14-0109501		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	05/17/2011
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	06/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2014

### 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 44-year-old female who sustained a vocational injury on May 17, 2011 when she tripped and fell. The clinical records provided for review document a working diagnosis of right shoulder impingement syndrome with tendonitis/bursitis. The report of an MRI of the right shoulder on February 20, 2014 showed trace fluid in the subacromial/subdeltoid bursa as well as surrounding biceps tendon suggestive of mild tenosynovitis. Acromioclavicular joint hypertrophy without gross compromise of the subacromial space and mild tendonitis without evidence of rotator cuff tear were also noted. The office note dated June 11, 2014 noted complaints of ongoing right shoulder pain, weakness and limited range of motion. Physical examination of the bilateral shoulders revealed tenderness to palpation of the anterior and lateral deltoid, biceps tendon, acromioclavicular joint, and anterior and lateral acromion on the right. Impingement test, Neer test, Hawkins test and empty can were all positive on the right. Range of motion was decreased in the right shoulder for flexion, abduction as well as internal and external rotation. Conservative treatment is documented to include physical therapy for the right shoulder; however, the documentation only supports the claimant had therapy following elbow surgery on the right. Previous documentation presented for review suggests the claimant underwent a cortisone injection to the right shoulder on March 5, 2014, however, the anatomic location of the injection is not provided for review. In the March 12, 2014 office notes it is noted that the cortisone injection provided significant moderation of her right shoulder pain and helped to increase her overall function. This review is for right shoulder arthroscopy, subacromial decompression.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopy subacromial decompression per 5/23/14 form QTY 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 214.

**Decision rationale:** California ACOEM Guidelines recommend documentation of a minimum of three to six months of continuous conservative treatment which should include formal physical therapy, activity modification, anti-inflammatories and subacromial injections prior to recommending and considering surgical intervention. There is a lack of documentation supporting that the claimant has had continuous conservative care prior to recommending and proceeding with surgical intervention and subsequently the request for the right shoulder arthroscopy, subacromial decompression cannot be considered medically necessary based on the documentation presented for review and in accordance with California MTUS and ACOEM Guidelines.

**Possible mumford procedure, right shoulder QTY 1: Upheld**

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

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

**Decision rationale:** The California MTUS and ACOEM Guidelines do not address this procedure. Based on the Official Disability Guidelines, the request for Mumford Procedure is not recommended as medically necessary. ODG Guidelines recommend that conservative treatment should be undertaken for a minimum of six weeks prior to considering and recommending surgical intervention and there should be corroborating subjective clinical findings as well as abnormal objective clinical findings along with abnormal imaging clinical studies suggesting that there is posttraumatic arthritis of the acromioclavicular joint prior to recommending and considering surgical intervention. The documentation presented for review fails to establish that there are subjective complaints, abnormal physical exam objective findings, and imaging clinical studies confirming that there is a diagnosis of posttraumatic arthritis of the acromioclavicular joint and subsequently based on the documentation presented for review and in accordance with the Official Disability Guidelines, the request for the Mumford procedure to the right shoulder cannot be considered medically necessary.

**Assistant Surgeon QTY 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines update 5/12/14: Surgical Assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Milliman Care Guidelines, 18th Edition, Assistant Surgeon Guidelines.

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

**Pre-op Medical Clearance QTY 1: 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 Examination and Consultation, page 127.

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

**Post-operative Physical Therapy, 3 x week x 4 weeks, right shoulder QTY 12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

**Decision rationale:** The proposed surgery is not recommended as medically necessary. Therefore, the request for postoperative physical therapy times twelve sessions is also not medically necessary.