

<b>Case Number:</b>	CM14-0025087		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	02/01/2013
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2014

### 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, has a subspecialty in and is licensed to practice in Mississippi. 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 injured worker is a 51-year-old female who was reportedly injured on February 1, 2013. The mechanism of injury is listed as cumulative trauma. The most recent progress note, dated October 3, 2013, indicated that there were ongoing complaints of neck pain, low back pain, right shoulder pain and bilateral foot pain. The physical examination demonstrated full range of motion of both shoulders and tenderness at the acromioclavicular joint. There was decreased range of motion of the lumbar spine and tenderness along the paraspinal muscles. There was decreased bilateral ankle motion and tenderness at the left Achilles tendon. There was normal cervical spine motion and tenderness along the lower cervical spine paraspinal muscles. There were diagnoses of mechanical cervical spine pain, right shoulder inflammation, lumbar spine strain, and Achilles tendon tenosynovitis. The treatment plan was to await an MRI of the right shoulder. An MRI of the right shoulder dated October 9, 2013, showed subacromial impingement, a superficial partial thickness tear, an undersurface partial thickness tear of the supraspinatus tendon and mild arthritis of the right acromioclavicular joint. A request was made for right shoulder surgery, preoperative medical clearance, postoperative physical therapy, the cold therapy unit, an E-stem unit, and abduction sling, a continuous passive motion (CPM) unit, and an assistant surgeon which was not certified in the pre-authorization process on January 31, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OUTPATIENT DIAGNOSTIC/OPERATIVE RIGHT SHOULDER ARTHROSCOPY, POSSIBLE ARTHROSCOPIC DECOMPRESSION WITH ACROMIOPLASTY, RESECTION OF CORACOACROMIAL LIGAMENT AND/OR BURSA AS INDICATED, MUMFORD PROCEDURE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 210-211.

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

**Decision rationale:** According to the American College of Occupational and Environmental Medicine, surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least three to six months before considering surgery. The injured employee is 53 years old, and there is no information in the attached medical record that other conservative care has been previously provided including physical therapy and cortisone injections. Such conservative care should be rendered prior to considering this individual for arthroscopic surgery. For these reasons, this request for arthroscopic surgery of the right shoulder is not medically necessary.

**PRE-OP MEDICAL CLEARANCE: 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 THREE (3) TIMES A WEEK FOR SIX (6) WEEKS FOR THE RIGHT SHOULDER: 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.

**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 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.

**E STIM UNIT:** 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.

**SLING WITH LARGE ABDUCTION PILLOW:** 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.

**CPM UNIT:** 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.

**ASSISTANT SURGEON:** 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.