

<b>Case Number:</b>	CM14-0053679		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	10/10/2011
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	04/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2014

### 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 Texas. 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 46-year-old female who reported an injury on 10/10/2011. The mechanism of injury was not specifically stated. The current diagnoses include bilateral shoulder impingement, bilateral carpal tunnel syndrome, cervical herniated nucleus pulposus, and lumbar herniated nucleus pulposus. The injured worker was evaluated on 03/21/2014. The injured worker reported persistent right shoulder pain and weakness. Physical examination revealed limited right shoulder range of motion, 4/5 strength, positive impingement sign, positive Neer and Hawkins sign, positive straight leg raising, and positive spasm in the thoracic and cervical spine. Treatment recommendations at that time included right shoulder arthroscopy with subacromial decompression and possible rotator cuff repair, preoperative clearance, and postoperative physical therapy.

### 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, distal clavicle excision and possible rotator cuff repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**Decision rationale:** The California American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. As per the documentation submitted, the injured worker presents with persistent pain and weakness in the right shoulder. Physical examination does reveal decreased range of motion, diminished strength, and positive impingement testing. However, there were no imaging studies provided for this review. There is also no mention of an exhaustion of conservative treatment. Therefore, the injured worker does not currently meet criteria for the requested procedure. As such, the request is not medically necessary and appropriate.

**Pre-operative medical clearance:** Upheld

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

**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.

**12 Post-operative physical therapy visits:** Upheld

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

**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.