

<b>Case Number:</b>	CM13-0035654		
<b>Date Assigned:</b>	06/09/2014	<b>Date of Injury:</b>	06/26/2013
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	09/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 47-year-old male who reported an injury on 06/26/2013. The mechanism of injury involved cumulative trauma. The current diagnoses are history of industrial injury with right shoulder impingement and partial rotator cuff tear. The injured worker presented on 08/20/2013, for an orthopedic evaluation with complaints of persistent shoulder pain. Upon examination of the bilateral shoulders, there was 180-degree forward flexion, 180-degree abduction, 90-degree external rotation, and internal rotation to T8. There was no evidence of atrophy of muscle wasting. Motor strength was 5/5 bilaterally, and sensation was intact. There was tenderness over the acromioclavicular joint. Additionally, the provider noted positive Neer's and Hawkin's impingement signs, with positive cross arm testing. Recommendation included a diagnostic and operative arthroscopy of the right shoulder. A Request for Authorization form was then submitted on 09/04/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic Debridement with Acromioplasty Resection of Coracoacromial Ligament and Burns and Possible Distal Clavicle Resection with Biceps Tenodesis: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG Treatment, Shoulder (Acute & Chronic), Indications for Surgery, Acromioplasty.

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

**Decision rationale:** The CA MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicate 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. In this case, it is noted that the injured worker has objective evidence of tenderness over the AC joint and positive Neer's and Hawkin's signs. However, there is no evidence of a significant functional deficit with regard to range of motion or strength. There is no mention of an exhaustion of conservative treatment. The request as submitted failed to indicate a specific body part to be treated. It is unclear whether the proposed surgery is for the left or right shoulder. Given the above, the request is not medically appropriate.

**Post-Operative Physical Therapy (12-sessions):** 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.

**DVT Prophylaxis:** 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.

**Levaquin 750mg, for 10 days, #20:** 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.

**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.

**Assisted 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.