

<b>Case Number:</b>	CM14-0005386		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	06/20/2012
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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. 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

### 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 sustained an industrial injury on 6/20/2012. She has reported loss of consciousness from a head trauma, and subsequent neck pain that radiated down right arm. Past surgical history included back surgery with instrumentation to correct scoliosis in 2008 and 2010. Electromyogram 11/1/13 with abnormal findings significant for carpal tunnel syndrome. The diagnoses have included cervical radiculitis, right shoulder impingement, right carpal tunnel syndrome, and right wrist extensor tenosynovitis. Treatment to date has included neck brace, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), muscle relaxer, steroid joint injections, physical therapy, and home exercise. On 10/3/13, complaints included right shoulder pain despite conservative measures including physical therapy, shoulder joint steroid injections, and rest. The right shoulder examination included positive impingement and Hawkins signs, painful arc from 100-170, 5/5 cuff strength with pain limitations. Diagnoses including cervical radiculopathy and partial cuff tear, and shoulder impingement. A shoulder joint injection was provided on this date. The most recent evaluation was dated 11/4/13. The IW was three month status post right wrist carpal tunnel release, and complained of right neck and shoulder pain, numbness, weakness. On 12/9/2013 Utilization Review non-certified a surgical procedure, right shoulder arthroscopy, subacromial decompression with acromioplasty, possible rotator cuff repair and possible bicep repair, noting the documentation did not support medical necessity. The MTUS, ACOEM, and ODG Guidelines were cited. On 1/13/2014, the injured worker submitted an application for IMR for review of surgical procedure, right shoulder

arthroscopy, subacromial decompression with acromioplasty, possible rotator cuff repair and possible bicep repair.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**SURGICAL PROCEDURE: RIGHT SHOULDER ARTHROSCOPY, AUBACROMIAL DECOMPRESSION WITH ACROMLOPLASTY, POSSIBLE ROTATOR CUFF REPAIR AND POSSIBLE BICEPS.:** 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:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 10/3/13. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 10/3/13 does not demonstrate evidence satisfying the above criteria. Therefore the determination is for non-certification.

**ULTRASLING:** 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 CHAPTER

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.