

<b>Case Number:</b>	CM15-0136686		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	07/14/2014
<b>Decision Date:</b>	08/21/2015	<b>UR Denial Date:</b>	06/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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, Indiana, Oregon  
 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 49 year old male who sustained an industrial injury on 7/14/14 he was retrieving a run- away vehicle, managed to get inside the vehicle and stop it but he hit another car and two days after the accident experienced bilateral shoulder pain radiating to the neck and upper extremities right greater than left. He was medically evaluated, had x-rays and computed tomography which was abnormal and surgery was recommended. He was placed on restricted duty but symptoms persisted. He received physical therapy. He currently complains of pain in the right shoulder that was present 75-80% of the time with a varying pain level of 2-10/10; left shoulder pain was present 50% of the time with a varying pain level of 2-10/10. His activities of daily living are limited as using the right and left upper extremities exacerbates his symptoms. He notes that prior to this injury he worked out 2-3 times per week with weights, surfing, basketball, golf. On physical exam there was bilateral shoulder tenderness to palpation with decreased range of motion, positive acromioclavicular joint compression test, impingement I, II and III bilaterally; right and left elbow show decreased range of motion; right and left wrists show decreased range of motion. Medication was Norco. Diagnoses include right shoulder subacromial impingement syndrome; left shoulder partial thickness supraspinatus tendon tear, acromioclavicular joint degenerative joint disease, subacromial impingement and adhesions. Treatments to date include medication; home exercise program; physical therapy. Diagnostics include ultrasound of bilateral shoulders (2/11/15) revealing left acromioclavicular joint hypertrophy/ osteophyte formation/subacromial narrowing, left rotator cuff tendinosis, left adhesions; right shoulder x-ray (2/11/15) showing acromioclavicular joint degenerative joint

disease, subacromial impingement. In the progress note dated 5/18/15 the treating provider's plan of care includes requests for right shoulder arthroscopic decompression with acromioplasty, resection of coracoacromial ligament/ bursa as indicated, distal clavicle resection; pre-operative medical clearance; post-operative rehabilitative therapy 3X4 (supervised); home continuous passive motion device, 45 days; surgi-stim unit, 90 days; cool care therapy unit (unspecified duration); shoulder immobilizer with abduction pillow; length of stay outpatient.

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

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

#### **Right Shoulder Arthroscopic decompression with acromioplasty, resection of coracoacromial ligament/bursa as indicated, distal clavicle resection: Upheld**

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

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

**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. 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 5/18/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the request does not adhere to guideline recommendations and is not medically necessary.

**Preoperative 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative Rehabilitative Therapy 3 x 4 weeks (supervised): 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 Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated service: Home Continuous Passive Motion Device 45 days:** 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 Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated services: Surgi Stim Unit 90 days:** 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 Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated service: Cool Care Therapy Unit (unspecified duration):** 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 Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated service: Shoulder Immobilizer with 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated Service: Length of Stay (LOS) out patient:** 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 Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.