

<b>Case Number:</b>	CM15-0162207		
<b>Date Assigned:</b>	08/28/2015	<b>Date of Injury:</b>	12/10/2004
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	08/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2015

### 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, Oregon, Washington  
 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 53 year old male, who sustained an industrial injury on 12-10-04. The injured worker has complaints of right shoulder pain, right arm, neck and right wrist pain. The documentation noted that the pain is associated with tingling, radiating pain, tenderness and fatigue. The diagnoses have included other specified disorders of bursae and tendons in shoulder region. Treatment to date has included left trigger finger release in 2005; left carpal tunnel release in 2008; underwent right trigger finger and carpal tunnel release in 2010; magnetic resonance imaging (MRI) of the right shoulder on 11-9-13 revealed rotator cuff tendinitis, acromioclavicular degenerative joint disease and a mass within the suprascapular notch measuring 3 by 1.3 by 1.0 centimeters, which appeared to be a multiloculated and multiseptated paralabral cyst extending to the spinoglenoid notch; electromyography/nerve conduction velocity on 4-3-14 revealed no evidence of ulnar nerve neuropathy at the cubital tunnel of the Guyon's canal and no evidence of cervical radiculopathy or brachial plexopathy; cortisone injections; tramadol; Flexeril; Ultracin topical cream and Flexeril. The request was for arthroscopic right shoulder decompression, distal clavicle resection, labral and or cuff debridement with aspiration and evacuation of suprascapular and spinoglenoid ganglion cysts; standard pre-operative medical clearance; post op rehabilitative therapy 3 x 4; associated surgical service, home continuous passive motion device; associated surgical service shoulder immobilizer with abduction pillow; associated surgical service sugi-stim unit times 90 days and associated surgical service coolcare cold therapy unit. Several documents within the submitted medical records are difficult to decipher.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic right shoulder decompression, Distal clavicle resection, Labral and/or cuff debridement with aspiration AND evacuation of suprascapular and spinoglenoid ganglion cysts:** 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), Shoulder - Indications for surgery - Acromioplasty.

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

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 209 and 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. 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 notes provided do not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is for non-certification. Based upon the CA MTUS Shoulder Chapter, pages 209 and 210 recommendations are made for surgical consultation when there are red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case the exam notes do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the request is not medically necessary.

**Standard pre-operative 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Post op rehabilitative therapy 3 x 4: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical service: Home CPM device: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical 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 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical service: Sugi-stim unit x 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 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical service: Coolcare 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.