

<b>Case Number:</b>	CM15-0183723		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	02/05/2012
<b>Decision Date:</b>	10/29/2015	<b>UR Denial Date:</b>	08/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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 61 year old female, who sustained an industrial injury on 02-05-2012. She has reported subsequent neck, right shoulder pain and hand pain and was diagnosed with right shoulder rotator cuff tendinitis and impingement, right hand carpal tunnel syndrome, right carpal tunnel syndrome and cervical strain with disc disease and radiculopathy. MRI on 07-16-2014 was noted to show impingement of the cervical spine on the left C5 nerve root. The injured worker was noted to be off work. Treatment to date has included pain medication, splinting, shoulder injection, selective nerve root blocks and surgery which were noted to have failed to significantly relieve the pain. In a progress note dated 08-04-2015, the injured worker reported right shoulder pain and right hand numbness and tingling as well as pain when attempting to use the arm and weakness of the arm. The injured worker reported difficulty with performing activities of daily living as well as with grasping, gripping, lifting, fine and gross manipulation and tactile discrimination. Objective examination findings showed restricted range of motion of the right shoulder, positive provocative testing, pain when attempting to place the arm behind the back, atrophy of the thenar eminence, pain with range of motion, positive Phalen's and Tinel's signs, inconclusive Finkelstein test and decreased right grip strength. A request for authorization of right shoulder arthroscopy-decompression, possible repair cuff, assistant surgeon and associated surgical service: laboratory was submitted. As per the 08-31-2015 utilization review, the requests for right shoulder arthroscopy-decompression, possible repair cuff, assistant surgeon and associated surgical service: laboratory were non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Right Shoulder Arthroscopy Decompression/Possible Repair Cuff: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder section, acromioplasty surgery.

**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 8/4/15. 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 8/4/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is for not medically necessary.

**Assistant Surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder section, acromioplasty surgery.

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

**Associated Surgical Service: Laboratory:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder section, acromioplasty surgery.

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