

<b>Case Number:</b>	CM15-0183808		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	07/20/2014
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	09/09/2015
<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, 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 45 year old male, who sustained an industrial injury on 7-20-2014. The injured worker is undergoing treatment for: right shoulder internal derangement-impingement syndrome, right shoulder acromioclavicular joint osteoarthritis. On 7-22-2015, he reported right shoulder, right jaw, neck, and mid back pain. He rated his pain 8 out of 10. He also reported associated weakness and numbness in the hand and arm. He indicted activity such as lifting, pushing and pulling aggravate his pain. Physical examination revealed tenderness, positive neer's impingement, Hawkins impingement and empty can testing, and a decreased range of motion of the right shoulder. On 9-16-2015, a supplemental report indicated physical therapy gave no relief and noted physical examination to reveal tenderness, decreased strength, and range of motion to the right shoulder. The treatment and diagnostic testing to date has included: medications, at least 12 physical therapy, magnetic resonance imaging (1-24-15) revealed acromioclavicular osteoarthritis, supraspinatus tendinosis, and infraspinatus tendinosis; QME (6-26-15), wrist brace, knee brace. Medications have included: Cyclobenzaprine, Naproxen, and Protonix. Current work status: He is currently off work and on 7-22-15 his work status is noted as restricted. The request for authorization is for: right shoulder arthroscopy, subacromial decompression, and distal clavicle excision; one pre-operative medical clearance (specimen fat stain, feces, urine, or respiratory secretions), routine venipuncture, electrocardiogram, complete; one post-operative physical therapy (electrical stimulation, infrared therapy, therapeutic exercises); one right shoulder sling; and one cold therapy unit. The UR dated 9-9-2015: non-certified the request for : right shoulder arthroscopy, subacromial decompression, and distal

clavicle excision; one pre-operative medical clearance (specimen fat stain, feces, urine, or respiratory secretions), routine venipuncture, electrocardiogram, complete; one post-operative physical therapy (electrical stimulation, infrared therapy, therapeutic exercises); one right shoulder sling; and one cold therapy unit.

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

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

**One (1) right shoulder arthroscopy, subacromial decompression and distal clavicle excision:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. 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 records do 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.

**One (1) pre-operative 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**One (1) post operative physical therapy:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical services: One (1) shoulder sling:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical services: One (1) 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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