

Case Number:	CM15-0189570		
Date Assigned:	10/01/2015	Date of Injury:	04/13/2006
Decision Date:	12/15/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	09/25/2015

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 46 year old, female who sustained a work related injury on 4-13-06. A review of the medical records shows she is being treated for right shoulder pain. Treatments have included right shoulder subacromial space steroid injections (7-10 days of "moderate temporary relief", the last one lasted 3 days) and physical therapy. Current medications include Norco, Mobic, Flexeril and Tramadol. In the Orthopedic History and Physical, the injured worker reports right shoulder pain. On physical exam dated 7-23-15, right shoulder is sore and tender over the anterolateral acromial margin area, acromioclavicular and subacromial space. She has active but painful right shoulder range of motion, which is decreased. Motor strength and sensation are normal. X-rays of right shoulder done in office this visit reveal "findings that can be associated with impingement syndrome and rotator cuff disease. There is cupping of the undersurface of the acromium with prominent downsloping of the anterolateral acromial margin and spurring inferiorly at the joint level." MRI right shoulder dated 4-10-12 reveals (in this History and Physical note) "the presence of hypertrophic spurring projecting inferiorly from the acromioclavicular joint and moderate downsloping of the anterolateral acromial margin. The subjacent supraspinatus tendon demonstrates signal change and thickening anterolaterally subjacent to the acromium and hypertrophic acromioclavicular joint." Working status unknown at this time. The treatment plan includes a request for right shoulder surgery. The Request for Authorization dated 9-16-15 has requests for right shoulder arthroscopic surgery and for associated services. In the Utilization Review dated 9-22-15, the requested treatments of a right shoulder exam under anesthesia, arthroscopic subacromial decompression, possible distal

clavicle resection and possible rotator cuff repair and associated services are not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder exam under anesthesia, arthroscopic subacromial decompression, possible distal clavicle resection, and possible rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for impingement syndrome, Rotator cuff repair, Partial claviculectomy.

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. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the imaging does not demonstrate full thickness rotator cuff tear. The request is not medically necessary.

Associated surgical service: Outpatient facility: 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.

Pre-operative labs: Complete blood count (CBC): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing, preoperative lab testing.

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.

Pre-operative labs: Complete metabolic panel (CMP): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing, preoperative lab testing.

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.

Pre-operative chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing.

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.

Pre-operative electrocardiogram (EKG): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative electrocardiogram.

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.