

<b>Case Number:</b>	CM15-0199947		
<b>Date Assigned:</b>	10/15/2015	<b>Date of Injury:</b>	08/06/2013
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/12/2015

### 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 50 year old male, who sustained an industrial injury on 8-6-13. Medical records indicate that the injured worker is undergoing treatment for mild right cervical five and right lumbar five radiculopathy, chronic myofascial pain syndrome of the cervical and thoracolumbar spine (moderate to severe), bilateral carpal tunnel syndrome, ulnar neuropathy and chronic sprain injury of the right shoulder and right knee. The injured worker was released to work on modified duties. However, the injured workers current work status was not identified. On (9-4-15) the injured worker complained of frequent pain and numbness in the right hand, painful movements of the right shoulder, knee pain and constant low back pain. The pain was rated 6-8 out of 10 without medications and 1-2 with medications on the visual analogue scale. Examination of the right shoulder revealed a painful and slightly too moderately decreased range of motion in all directions. Sensation to fine touch and pinprick was decreased in the lateral aspect of the right arm. Grip strength was decreased at 4-5 in the right hand. Treatment and evaluation to date has included medications, trigger point injections and a home exercise program. Current medications include Naproxen, Tramadol-Acetaminophen, Welbutrin SR and Norco. The current treatment requests include a right shoulder arthroscopic examination, decompression with Mumford Procedure, pre-operative clearance, assistant surgeon, cold therapy unit for the right shoulder, Ultrasling for the right shoulder and post-operative physical therapy visits # 12 for the right shoulder. The Utilization Review documentation dated 9-15-15 non-certified the requests for a right shoulder arthroscopic examination, decompression with Mumford Procedure, pre-operative clearance, assistant surgeon, cold therapy unit for the right

shoulder, Ultrasling for the right shoulder and post-operative physical therapy visits # 12 for the right shoulder.

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

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

#### **Right Shoulder Arthroscopic Exam, Decompression with Mumford Procedure: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

**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:** Based upon the CA MTUS Shoulder Chapter, pages 209-210, recommendations are made for surgical consultation when there is 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 imaging does not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the request is not medically necessary.

#### **Pre-Op 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.

#### **Associated Surgical Service: Assistant Surgeon: 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.

**Post-Op PT x 12 Visits for The Right Shoulder: 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.

**Associated Surgical Service: Ultrasling for The Right Shoulder: 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.

**Associated Surgical Service: Cold Therapy Unit for The Right Shoulder: 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.