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| <b>Case Number:</b>   | CM15-0066508 |                              |            |
| <b>Date Assigned:</b> | 04/21/2015   | <b>Date of Injury:</b>       | 04/08/2010 |
| <b>Decision Date:</b> | 08/04/2015   | <b>UR Denial Date:</b>       | 04/03/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/08/2015 |

### 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  
 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 57 year old male, who sustained an industrial injury on April 8, 2010. He reported low back and shoulder pain due to repetitive lifting. The injured worker was diagnosed as having impingement syndrome of the right shoulder - status post modified Mumford procedure, labral repair, and rotator cuff repair. Diagnostic studies to date have included an MR arthrogram of the right shoulder from 5/8/14. MR arthrogram demonstrates postsurgical findings of supraspinatus tendon repair without evidence of re-tear of the labrum and subacromial decompression with acromioplasty and Mumford procedure. Treatment to date has included work modifications, shoulder steroid injections, physical therapy, ice/heat, and medications including pain, proton pump inhibitor, and non-steroidal anti-inflammatory. On March 13, 2015, the injured worker complains of quite a bit of right shoulder pain, which occurs daily even with light exercises. His pain is increased with general light cleaning. He reported he would like to proceed with surgery. The physical exam revealed right shoulder, rotator cuff, and biceps tendon tenderness, decreased abduction, and positive impingement and Hawkin's sign. He is not currently working. The treatment plan includes a modified Mumford procedure, chest x-ray, polar care unit x 21 day rental, Amoxicillin 875mg, Zofran 8mg, and Topamax 50mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy with Decompression, Modified Mumford Procedure, and Evaluation of Labrum and Biceps Tendon: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Shoulder Procedure Summary, Online Version, Diagnostic arthroscopy, Indications for Surgery - Acromioplasty, Partial claviclectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder section, Partial Claviclectomy.

**Decision rationale:** Based upon the CA MTUS Shoulder Chapter, Pgs 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 exam note from 3/13/15 and the imaging findings from 5/8/14 do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the determination is not medically necessary.

**Pre-Operative Chest X-Ray: 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) Low Back, Preoperative testing.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Polar Care Unit x 21 Day Rental: 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 ODG Shoulder, Continuous flow cryotherapy.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Amoxicillin 875mg 1 tablet twice a day: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Zofran 8mg as needed #20: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Topamax 50mg 1 tablet twice a day #120: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.