

<b>Case Number:</b>	CM15-0082290		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	08/10/2012
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	04/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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 51 year old male who sustained an industrial injury on 8/10/12 when he sustained a crush injury to his right hand, putting a traction type injury to the right upper extremity in which the right shoulder was also injured. Currently (1/5/15), he has some pain in his right elbow and neck; minimal pain in the right wrist and hand and significant pain in the right shoulder. He has limits with activities of daily living that involve cooking cleaning, self-care, pushing, pulling and lifting with the right upper extremity. Medications and treatments were not specifically identified. Diagnoses include status post right wrist and hand crush injury with essential resolution of the injury; right shoulder subacromial bursitis with impingement and significant acromioclavicular joint symptoms with acromioclavicular joint degenerative joint disease; right elbow strain; cervical strain with minimal symptoms and without radiculopathy. Diagnostics include right shoulder MRI (4/13/12) indicating severe arthrosis of the acromioclavicular joint and intact rotator cuff with impingement and bursitis. In the progress note dated 1/5/15 the treating provider's plan of care includes a requested arthroscopic right shoulder surgery with subacromial decompression with distal clavicle resection and evaluation with post-operative therapy available up to 24 visits. He would need pre-operative clearance as well.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right arthroscopy shoulder surgery: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. 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 that is not present in the submitted clinical information from 1/5/15. 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 1/5/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. There is no evidence in the submitted records of 3 months of continuous conservative care like physical therapy. Based on the above the requested procedure is not medically necessary.

**Preoperative clearance, EKG, and labs CBC, PT, PTT, Chem 12 and UA: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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.

**Postoperative physical therapy 3x4 for the right shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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: Chest x-ray: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG shoulder.

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