

<b>Case Number:</b>	CM14-0212383		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	04/08/2013
<b>Decision Date:</b>	05/29/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

### 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, Sports Medicine

### 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 54-year-old female who sustained an industrial injury on 04/08/2013. The injured worker was diagnosed as having right shoulder impingement syndrome, and right shoulder severe bursitis. Treatment to date has included diagnostic x-rays and CT scans. She has had physical therapy, and a cortisone injection, which have failed to significantly improve her symptoms. She also takes Ibuprofen and Metformin for pain. Right arm pain is 4/10 without medication and 1/10 with medications. The injured worker presented on 11/21/2014 for a follow-up evaluation. It was noted that the injured worker had completed 6 sessions of physical therapy with mild improvement in symptoms. The injured worker noted right shoulder pain radiating into the right side of the neck, down into the hand, and associated headaches. The current medication regimen includes ibuprofen 800 mg and metformin 500 mg. Upon examination, there is palpable tenderness over the acromion, deltoid bursa, acromioclavicular joint, coracoid process, lesser and greater tuberosities, trapezius musculature, posterior shoulder musculature, and supraspinatus/infraspinatus musculature. There was positive impingement sign on the right, as well. Treatment recommendations at that included a right shoulder arthroscopy with acromioplasty. A postoperative sling, as well as postoperative physical therapy and preoperative clearance was also recommended. There was no request for authorization form submitted for review. The official MRI of the right shoulder on 10/01/2014 was submitted for review and indicated no evidence of a full thickness tear or atrophy of the muscle belly of the rotator cuff, mild tendinosis involving the supraspinatus insertion, and subacromial rotator cuff impingement.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Arthroscopy with Acromioplasty of the Right Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG Shoulder, Surgery for Impingement Syndrome, Indications for Surgery - Acromioplasty.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. In this case, it is noted that the injured worker has completed a short course of physical therapy. However, there was no documentation of significant functional deficits upon examination. The medical necessity for the requested surgical procedure has not been established. There is no evidence of an exhaustion of all conservative treatment for at least 3 months prior to the request for an arthroscopy with acromioplasty. Given the above, the request is not medically necessary.

### **Associated Surgical Service: Sling for the Right Shoulder (purchase): 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.

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

### **Associated Surgical Service: 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 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.

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

**Initial Post-Op Physiotherapy (3 times weekly):** 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.