

<b>Case Number:</b>	CM15-0012829		
<b>Date Assigned:</b>	01/30/2015	<b>Date of Injury:</b>	07/01/2011
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	12/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/22/2015

### 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 39 year old female who sustained a cumulative work related injury to the upper extremities and shoulders while employed as a typist on July 1, 2011. The injured worker was diagnosed with left shoulder impingement. This review is based on the physician's request for surgical intervention. According to the treating physician's progress report on December 15, 2014 the injured worker has bilateral Hawkins and Neer impingement signs and pain with cross body adduction. Neurovascular was noted as intact. The injured worker has positive arc pain from 60-110 degrees of bilateral shoulder motion. A Magnetic resonance imaging (MRI) in February 2013 demonstrated Type II acromion on the left and Type III on the right side. No rotator cuff or labral tear was noted. The patient continues to experience bilateral shoulder pain with stiffness and weakness. Current medications are Ultram and Flexeril. Current treatment modalities consist of conservative treatment and a bilateral shoulder injection on October 29, 2014 according to the medical report on November 13, 2014. There were no results noted from this procedure. The injured worker was recommended to remain on work without restrictions. The treating physician requested authorization for Left shoulder arthroscopy, possible arthroscopic decompression with acromioplasty, resection, Mumford procedure; Assistant surgeon; Pre-op medical clearance; Post op physical therapy 3 x 6; E-Stimulator purchase; Cold Therapy Unit (CTU) purchase; Continuous Passive Motion (CPM) Purchase; Sling with large abduction pillow. On December 29, 2014 the Utilization Review denied certification for Left shoulder arthroscopy, possible arthroscopic decompression with acromioplasty, resection, Mumford procedure; Assistant surgeon; Pre-op medical clearance; Post op physical therapy 3 x

6; E-Stimulator purchase; Cold Therapy Unit (CTU) purchase; Continuous Passive Motion (CPM) unit Purchase; Sling with large abduction pillow. The surgical procedure was denied therefore all others requests were not authorized. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG).

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

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

**Left shoulder arthroscopy, possible arthroscopic decompression with acromioplasty, resection, Mumford procedure: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

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

**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 12/15/14. 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 12/15/14 does not demonstrate evidence satisfying the above criteria. Therefore the determination is for non-certification.

**Assistant surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopedic Surgeons

**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.

**Post op physical therapy 3 x 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

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

**Associated surgical service: CTU purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

**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: E-Stim purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

**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: Sling with large abduction pillow:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

**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: CPM purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Procedure Summary

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Preoperative testing

**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.