

<b>Case Number:</b>	CM15-0116527		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	04/17/2012
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	06/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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 36 year old male, who sustained an industrial injury on 4/17/12. The mechanism and initial symptoms experienced by the injured worker were not included in the documentation. The injured worker is diagnosed with right shoulder impingement and low back pain. Treatment to date has included medication, TENS unit, physical therapy and cortisone injection(s). Currently, the injured worker complains of continued low back and right shoulder pain. The injured worker was evaluated on 2/16/15 and noted to have continued back and right shoulder pain. The back pain is causing back stiffening. There is no improvement in the right shoulder; however it is no worse. On 3/30/15 the injured worker was evaluated and noted to have increased back pain and stiffness as well as increased shoulder pain, which is interfering with his activities of daily living. There is also documentation regarding decreased range of motion due to pain. A noted dated 5/8/15 states the right shoulder shows signs of impingement. It also states there is low back tenderness. The injured worker was evaluated on 6/18/15 with documentation stating he continues to experience right shoulder and back pain. The exam to the right shoulder continues to indicate an impingement. The note also indicates physical therapy did not achieve any long lasting benefit nor did the cortisone injection. He did borrow a TENS unit, but documentation of efficacy is not included. Right shoulder arthroscopic subacromial decompression, pre-operative medical clearance and testing, post-operative physical therapy treatments two times a week for six weeks is being requested to decrease/eliminate his pain and improve his ability to engage in activities of daily living.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Right shoulder arthroscopic subacromial decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter, Surgery for impingement syndrome, Indications for Surgery-Acromioplasty.

**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 section.

**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. 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 MRI noted specifically that there was no fluid in the subacromial/subdeltoid bursa indicative of a surgical lesion. Based on this information, the request is not medically necessary.

### **Pre-operative medical clearance and testing: 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.

### **Post-operative physical therapy treatments 2 times a week for 6 weeks: 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.