

<b>Case Number:</b>	CM15-0116552		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	03/22/2012
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	05/14/2015
<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

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 33 year old female, who sustained an industrial injury on 3/22/12. The injured worker has complaints of right shoulder and cervical pain. The injured worker has spasm and tenderness observed in the paravertebral muscles of the cervical spine with decreased range of motion on flexion and extension. Dysesthesia is noted in C5, C6 and C7 dermatomal distribution bilaterally. The diagnoses have included cervical radiculopathy; shoulder impingement and disorders of bursae and tendons in shoulder region, unspecified. Treatment to date has included injections; physical therapy and magnetic resonance imaging (MRI) of the cervical spine dated 11/5/14 showed evidence of posterior disc bulge measuring 2 to 3 millimeter at level C4-C5 with annular fissure in the posterior aspect of the disc and 3 millimeter at level C5-C6 and mild level C5-C6, neural foraminal narrowing noted. On 4/29/15 the patient complained of right shoulder pain. The request was for right shoulder diagnostic arthroscopy, possible synovectomy, labral repair, arthroscopic subacromial decompression, distal clavicle excision and rotator cuff repair; preoperative medical clearance and post- operative physical therapy, 12 sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Diagnostic Arthroscopy, possible Synovectomy, Labral Repair, Arthroscopic Subacromial Decompression, Distal Clavicle Excision and Rotator Cuff Repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

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

**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. In addition, the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 4/29/15 do not demonstrate 4 months of failure of activity modification. The physical exam from 4/29/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore, the request is not medically necessary.

**Preoperative Medical Clearance: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Society of General Internal Medicine, online.

**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.

**Post-operative physical therapy, 12 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211, 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.