

<b>Case Number:</b>	CM15-0121106		
<b>Date Assigned:</b>	07/02/2015	<b>Date of Injury:</b>	06/10/2013
<b>Decision Date:</b>	09/11/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2015

### 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 61 year old male with an industrial injury dated 06/10/2013. The injured worker's diagnoses include right greater trochanteric bursitis, right cervical radiculopathy with sensory los, right shoulder impingement with acromioclavicular joint (AC) joint degenerative joint disease, bilateral lumbar radiculopath , L1-S1 spondylosis, L4-5 and L5-S1 stenosis, left shoulder acromioclavicular joint (AC) joint arthritis, left shoulder impingement syndrome with AC joint degenerative joint disease, L5-S1 anterolisthesis and right knee lateral meniscal tear status post partial lateral meniscectomy. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 05/27/2015, the injured worker reported neck pain radiating into the bilateral trapezius and mid scapular region. The injured worker also reported right greater than left shoulder pain and low back pain radiating to the right buttocks wrapping around to the bilateral groins. The injured worker rated pain a 7-8/10 with medication and a 9-10/10 without medication. The treating physician reported that the right shoulder remains symptomatic with signs of impingement and acromioclavicular joint (AC) joint degenerative disc disease which was found on Magnetic Resonance Imaging (MRI) scan and physical exam. The treating physician reported that the right shoulder corticosteroid were diagnostic for the acromioclavicular joint (AC) and subacromial space, but did not resolve symptoms following therapy. The treating physician also reported that the left shoulder has left subacromial impingement and acromioclavicular joint (AC) joint degenerative joint disease which has worsened over two years due to compensation from right shoulder pain. The treating physician prescribed services for arthroscopy & distal clavicle resection of the right shoulder,

assistant surgeon, preoperative medical clearance, post-operative shoulder immobilizer, physical therapy for the left shoulder, twice a week for three weeks and Oxycodone 10mg #180, now under review.

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

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

**Arthroscopy & distal clavicle resection of 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:** Based upon the CA MTUS Shoulder Chapter, Pgs 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for posttraumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case there is no official MRI interpretation submitted documenting the degree of arthritis in the AC joint. The request is not medically necessary.

**Assistant surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back; Surgical assistant.

**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.

**Preoperative medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.guideline.gov/content.aspx?id=48408](http://www.guideline.gov/content.aspx?id=48408);

**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.

**Physical therapy for the left shoulder, twice a week for three weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

**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.

**Post operative shoulder immobilizer:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder; Immobilization.

**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.

**Oxycodone 10mg #180, 1 tab q 4h:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80 and 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. In this case, there is lack of demonstrated functional improvement, percentage of relief, Therefore the request is not medically necessary.