

<b>Case Number:</b>	CM15-0125034		
<b>Date Assigned:</b>	07/10/2015	<b>Date of Injury:</b>	05/02/2013
<b>Decision Date:</b>	08/06/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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 42 year old male, who sustained an industrial injury on 5/2/13. He has reported initial complaints of neck pain, bilateral shoulder pain, bilateral elbow pain and bilateral wrist pain due to repetitive work. The diagnoses have included right shoulder impingement syndrome, other affections of the shoulder region, lateral epicondylitis of the elbow, mononeuritis of the upper limb, mononeuritis multiplex, and hand sprain/strain. Treatment to date has included medications, diagnostics, off work, injections, physical therapy and other modalities. Currently, as per the physician progress note dated 4/18/15, the injured worker complains of pain in the right and left shoulders all the time. The pain radiates down into the right neck and into both arms and hands. There is tingling in the fingers of both hands. There is a popping sensation in the right shoulder. There are also complaints of weakness in the hands. The physical exam of the right shoulder reveals that it forward flexes to 160 degrees, abduction 150 degrees, external rotation is 80 and internal rotation is 70. The impingement sign is positive and there is pain across the right shoulder posteriorly. The diagnostic testing that was performed included x-ray and Magnetic Resonance Imaging (MRI) of the right shoulder. The physician notes that the injured worker is a candidate for right shoulder surgery. Work status is modified. The physician requested treatments included Right shoulder arthroscopy and subacromial decompression, for submitted diagnosis of right shoulder impingement as an outpatient, Related surgical service: Medical clearance, for submitted diagnosis of right shoulder impingement, as an outpatient and Related surgical service: Twelve post-operative physical therapy visits for the

right shoulder, three times weekly for four weeks, for submitted diagnosis of right shoulder impingement, as an outpatient.

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

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

**Associated surgical service: Medical clearance, for submitted diagnosis of right shoulder impingement, as an outpatient: Upheld**

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

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

**Right shoulder arthroscopy and subacromial decompression, for submitted diagnosis of right shoulder impingement, as an outpatient: Upheld**

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

**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.

**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 exam note from 4/18/15 does not demonstrate evidence satisfying the above criteria notably the painful arc of motion. This note also mentions that the examiner feels the most of the findings are subjective complaints. Therefore, the request does not adhere to guideline recommendations and is not medically necessary.

**Associated surgical service: Twelve post-operative physical therapy visits for the right shoulder, three times weekly for four weeks, for submitted diagnosis of right shoulder impingement, as an outpatient: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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