

<b>Case Number:</b>	CM15-0169673		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	03/02/2000
<b>Decision Date:</b>	11/02/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2015

### 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:

This is a 57-year-old female worker who was injured on 03-02-2000. The medical records reviewed indicated the injured worker (IW) was treated for shoulder impingement, right; acromioclavicular arthritis, right. In the treating provider's notes on 8-4-2015, the IW had right shoulder pain rated 6 out of 10. She had a cortisone injection to the right shoulder on 6-23-2015 that she stated helped her pain for two to three weeks. The right shoulder was tender to palpation and crepitus was present. Range of motion was limited. Strength was 5 out of 5 with internal and external rotation. Hawkins test, Speed's test and supraspinatus stress test were positive. She was given another cortisone injection. The progress notes dated 8-11-2015 indicated the IW's medications provided effective pain relief and allowed her to "experience less pain and be more active from day to day performing activities of daily living". She rated her average pain in the previous week 5 out of 10 with pain medications and her worst pain was 9 out of 10 without medications. On examination, right shoulder range of motion was decreased with internal rotation and abduction due to pain. Treatments to date include medications, including Norco; right shoulder arthroscopy (x 2); home exercise program; and cortisone injections. MRI of the right shoulder on 3-19-2015 showed hypertrophic degenerative changes of the acromioclavicular joint with subacromial osteophytes and subacromial or subdeltoid bursitis; and superficial fraying of the supraspinatus tendon. The findings were suggestive of impingement. The notes dated 6-23-2015 indicated the IW was unable to work. A Request for Authorization dated 8-6-2015 asked for one right shoulder arthroscopy vs open distal clavicle excision and subacromial decompression with possible rotator cuff repair; one outpatient facility; a preoperative exam; and 12 sessions of postoperative physical therapy. The Utilization Review on 8-14-2013 denied the request for one right shoulder arthroscopy vs open distal clavicle excision and subacromial

decompression with possible rotator cuff repair; one outpatient facility; a preoperative exam; and 12 sessions of postoperative physical therapy. The records supported the right shoulder was improved with PT and medications and the MRI did not reveal tearing of the rotator cuff; the associated surgical services were denied because the surgery was denied.

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

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

#### **Right Shoulder Arthroscopy vs open distal clavicle excision and subacromial decompression with possible rotator cuff repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic).

**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:** 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 imaging does not demonstrate full thickness rotator cuff tear. The request is not medically necessary.

#### **Associated Surgical Service: Outpatient Facility: 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

#### **Pre-op Exam: 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

#### **12 sessions of Post-op Physical Therapy: 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