

<b>Case Number:</b>	CM15-0172285		
<b>Date Assigned:</b>	09/14/2015	<b>Date of Injury:</b>	08/27/2012
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	08/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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 46 year old female with a date of injury on 8-27-2012. A review of the medical records indicates that the injured worker is undergoing treatment for chronic cervicgia, probable recurrent left shoulder rotator cuff tear, closed head injury with chronic post-traumatic headaches versus cervicogenic headaches and chronic intractable pain with narcotic tolerance. She was noted to be status post C3-6 anterior cervical discectomy and fusion and status post left shoulder arthroscopy and open rotator cuff repair. According to the medical records (5-13-2015 to 7-23-2015), the injured worker complained of neck pain rated seven to nine out of ten. She also complained of headaches. She complained of bilateral shoulder pain rated six to seven out of ten. Per the treating physician (7-23-2015), the employee was temporarily totally disabled. The physical exam (5-13-2015 to 7-23-2015) of the shoulders revealed palpable tenderness over the left acromioclavicular joint. There was reduced range of motion of the left shoulder. There was positive crossed arm sign on the left. It was noted that there was no evidence of rotator cuff tear on the computed tomography-arthrogram. A left shoulder acromioclavicular block was administered (7-23-2015). Per the treating physician "Following the injection, her symptoms significantly improved by approximately 80 percent. This is consistent with symptomatic acromioclavicular degenerative joint disease." The request for authorization dated 7-23-2015 was for left shoulder arthroscopy and related services. The original Utilization Review (UR) (8-5-2015) denied a request for left shoulder arthroscopy with distal clavicle resection with pre-operative medical clearance including a pre-operative chest x-ray and assistant surgeon.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy with distal clavicle resection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. 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 post traumatic 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 was an injection with good relief, but no evidence that symptoms have returned. The request is not medically necessary.

**Associated surgical service: Assistant surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Pre-operative medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Pre-operative chest x-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 sling for the left shoulder:** 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 Chapter, Post-operative Abduction Pillow Sling.

**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 physiotherapy for the left shoulder (18 sessions: 3 times per week for 6 weeks):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**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.