

<b>Case Number:</b>	CM15-0177421		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	06/04/2012
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2015

### 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 58 year old female, who sustained an industrial injury on June 12, 2012. She reported shoulder pain and bilateral upper extremity pain after lifting a patient at work. The injured worker was diagnosed as having acromioclavicular (AC) arthritis. Treatment to date has included diagnostic studies, physical therapy, TENS unit for 5 months with noted 50% improvement in pain, medications and work restrictions. Currently, the injured worker continues to report neck, thoracic and right upper extremity pain with associated weakness and numbness, low back pain and pain radiating to the right leg. The injured worker reported an industrial injury in 2012, resulting in the above noted pain. She was without complete resolution of the pain. Evaluation on August 18, 2015, revealed continued pain as noted. It was noted she was now cleared for modified duty. It was noted she had not reached maximal medical improvement. It was noted cervical transforaminal epidural steroid injection (TFESI) on May 28, 2015, improved her pain by greater than 50% however, the right shoulder pain was not improved and continued to be severe. Evaluation on August 27, 2015, revealed continued pain as noted. Right shoulder examination revealed decreased flexion at 160, abduction at 160, internal rotation at 30 and decreased strength. Magnetic resonance imaging (MRI) of the right shoulder on August 11, 2015, revealed cuff tendinopathy and mild subacromial bursal inflammation with moderate degeneration and hypertrophy of the AC joint consistent with minor mass effect on the superior cuff. Also noted was glenohumeral capsulitis. It was noted her history and physical exam findings were consistent with a rotator cuff tear and right shoulder arthroscopic distal clavicle

resection and subacromial decompression was recommended. The RFA included requests for Associated Surgical Service: Cold Therapy Unit, Associated Surgical Service: Sling, Post-Op PT (Right Shoulder) 2-3 x 6, Pre-Op Basic Metabolic Panel Pre-Op EKG and Right Shoulder Arthroscopic Distal Clavicle Resection and Subacromial Decompression and was non-certified on the utilization review (UR) on September 4, 2015.

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

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

**Right Shoulder Arthroscopic Distal Clavicle Resection and Subacromial Decompression:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Partial claviclectomy.

**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, the exam note from 8/27/15 and the imaging findings from 8/11/15 do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the determination is for not medically necessary.

**Pre-Op EKG:** 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) low back, preoperative testing.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-Op Basic Metabolic Panel:** 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) low back, preoperative testing.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Post-Op PT (Right Shoulder) 2-3 x 6:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Sling:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Cold Therapy Unit:** 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, continuous flow cryotherapy.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.