

<b>Case Number:</b>	CM15-0072400		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	01/09/2015
<b>Decision Date:</b>	06/10/2015	<b>UR Denial Date:</b>	03/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2015

### 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 35-year-old female with an industrial injury dated 01/09/2015. The mechanism of injury is documented as lifting a heavy trash bag and feeling a pulling sensation in her right shoulder. She developed discomfort and pain to the anterolateral aspect of her right shoulder that remained persistent. Her diagnosis was chronic impingement syndrome of right shoulder. Prior treatments included physical therapy, acupuncture, medication and subacromial steroid injection. MRI showed considerable inflammation of her rotator cuff without any full thickness tears (per provider). At presentation on 03/18/2015, she was complaining of a sharp stabbing pain located along the anterolateral aspect of the right shoulder associated with any type of activity that requires her to reach, lift, push or pull with her right arm. She denies any numbness or tingling. She states whenever she rolls onto her right shoulder at night it frequently wakes her due to discomfort. Physical examination of the cervical spine revealed some mild tenderness in the trapezius muscle at the base of the right side of her neck. Range of motion was normal in the cervical spine and right shoulder. Impingement sign and cross are test were positive. Neurological examination of the upper extremities was normal. The provider discussed conservative treatments along with surgical options. The injured worker states she was completely frustrated with non-operative treatments and "was not going anywhere with all the treatments she had had thus far" and wanted to proceed with surgical intervention to improve her shoulder discomfort. The treatment plan included a request for right shoulder arthroscopic subacromial decompression with open distal clavicle excision and possible rotator cuff repair,

post-operative physical therapy and durable medical equipment (cold therapy unit for right shoulder).

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

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

#### **Right Shoulder Arthroscopic Subacromial decompression with Open Distal Clavicle Excision, Possible Rotator Cuff Repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 209, 214, 211, 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter: Surgery for Impingement Syndrome, indication for Surgery- Acromioplasty.

**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. 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 injury is 1/9/15 and physical therapy was instituted after that. Given the early course of disease and the absence of red flags like weakness or significant limitations in range of motion, maximal conservative care has not been documented. Furthermore, the MRI states that the AC joint is within normal limits. Radiographic evidence of arthrosis must be present to satisfy ODG shoulder guidelines for a distal clavicle excision. Based on the above, the request is not medically necessary.

#### **Post-Operative Physical Therapy to the Right Shoulder (2 times a week for 4 weeks): 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

#### **Associated Surgical Service: Cold Therapy Unit for the Right Shoulder (7-day rental): 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.