

<b>Case Number:</b>	CM13-0034866		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	02/20/2013
<b>Decision Date:</b>	02/07/2014	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant is a 55-year-old gentleman who was injured in a work related accident on February 20, 2013. Specific to the claimant's left shoulder, records indicate prior review of an MRI scan of the left shoulder from February 22, 2013 that showed a partial undersurface tear of the supraspinatus with bursitis, a superior labral tear and a tear to the humeral capsule. The most recent clinical progress report dated August 9, 2013 with [REDACTED] indicated ongoing subjective complaints of pain about the shoulder despite conservative care that has included therapy, medications and oral analgesics. Physical examination to the left shoulder showed mildly restricted range of motion at endpoints with positive tenderness over the supraspinatus and greater tuberosity, positive crepitation, restricted strength at 4/5 which was equal to the contralateral right shoulder, equal and symmetrical reflexes and positive AC joint compression testing, impingement signs, Speed and O'Brien's testing. Based on failed conservative care, surgical arthroscopy with decompression, distal clavicle resection with a labral repair versus debridement was recommended. &#x2013;

### IMR ISSUES, DECISIONS AND RATIONALES

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

**arthroscopic evaluation, arthroscopic left shoulder decompression, distal clavicle resection, labral debridement or repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation ODG, Shoulder Procedures.

**Decision rationale:** Based on California ACOEM Guidelines and supported by Official Disability Guideline criteria, surgical process would not be indicated. While the claimant is noted to have failed conservative care, there is no documentation of prior corticosteroid injections performed that would support the need, or guideline criteria for surgery for the diagnosis of impingement. The absence of the above, based on clinical Guidelines, would not support the above procedure

**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 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.

**Postoperative rehabilitative 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.

**45 day rental of a continuous passive motion unit:** 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 items/services are medically necessary.

**SurgiStim unit:** 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 items/services are medically necessary.

**CoolCare 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 cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated items/services are medically necessary

**large abduction pillow:** 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 items/services are medically necessary.