

<b>Case Number:</b>	CM13-0048030		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/09/2012
<b>Decision Date:</b>	05/19/2014	<b>UR Denial Date:</b>	09/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2013

### 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. The expert 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 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/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 59-year-old gentleman who sustained an injury to the left shoulder on 04/06/12. The clinical records provided for review included an MRI report of the left shoulder dated 12/12/12 revealing bursal surface tearing of the supraspinatus, infraspinatus tendinopathy, no full thickness tearing and a down sloping Type II acromion. Clinical follow up on 09/10/13 by [REDACTED] appealed the utilization review decision denying the need for left shoulder arthroscopy, decompression and AC joint decompression with rotator cuff repair, but did not document specific clinical findings or identify a change in claimant's clinical picture. The 10/21/13 assessment indicated a diagnosis of impingement syndrome of the left shoulder with subjective complaints of left greater than right shoulder pain, worse with activity. Physical examination showed 5/5 motor strength, pain on palpation over the AC joint with no other significant findings noted. Recommendation on 10/21/13 was for operative intervention. The treating physician documented specifically that the claimant had not had recent conservative treatment to either shoulder and discussed the possibility of an injection for the left shoulder to see if that would be of benefit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LEFT SHOULDER SAD WITH POSSIBLE AC JOINT DECOMPRESSION ROTATOR CUFF:** Upheld

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

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

**Decision rationale:** Based on California ACOEM Guidelines and supported by the Official Disability Guidelines, the proposed left shoulder subacromial decompression and AC joint decompression and rotator cuff repair would not be indicated. The office note of 10/21/13 documented that there has been no recent conservative care including injection therapy for the claimant's shoulder. ACOEM Guidelines recommend that conservative care including cortisone injections be carried out for three to six months prior to consideration of surgery. The claimant's imaging also fails to demonstrate AC joint findings to support the surgery. In absence of conservative treatment including injections, and supporting imaging studies, the surgery as proposed would not be medically necessary.

**POST OP POLAR CARE 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 services are medically necessary.

**ABDUCTION SLING #4:** 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.

**POST OP PHYSICAL THERAPY THREE TIMES FOUR FOR THE LEFT SHOULDER:**  
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.

**CPU RENTAL FOR THE 21 DAY RENTAL #5:** 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.