

<b>Case Number:</b>	CM14-0005394		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	06/14/2013
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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 Texas. 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 injured worker is a 58-year-old female who reported an injury on June 14, 2013 due to a fall. The injured worker reportedly sustained an injury to her left upper extremity. The injured worker was conservatively treated with physical therapy, medications, and activity modifications. The injured worker was evaluated on November 13, 2013. It was documented that the injured worker had persistent pain complaints and activity limitations of the left shoulder. Physical findings included pain with overhead motion, tenderness to the subacromial region, and a positive impingement sign. It was documented that the injured worker had a positive response to previous corticosteroid injections; however, this failed to provide long-term relief indicating that the injured worker was a candidate for left shoulder arthroscopy and subacromial decompression. It was noted within the documentation that the injured worker had undergone an MRI on November 1, 2013 that showed a type II acromion and tendinosis of the rotator cuff and biceps tendon. However, this was not provided for review. The injured worker's diagnoses included left wrist sprain, cubital tunnel symptoms, and shoulder traumatic impingement. The injured worker's treatment plan included a surgical intervention. An appeal request was made on December 11, 2013 for the denial of a left shoulder surgery. It was noted that the injured worker had 3/10 pain aggravated with repetitive use and overhead reaching. It was noted that the previous denial was based on a guideline recommendation of 2 to 3 corticosteroid injections and that the injured worker had only had 1 corticosteroid injection. It was noted that the treating physician felt the injured worker's reaction to the diagnostic injection indicated that the injured worker was an appropriate candidate for surgical intervention.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LEFT SHOULDER SCOPE WITH DEBRIDEMENT, SAD: 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): 210-211.

**Decision rationale:** The American College of Occupational and Environmental Medicine recommends surgical intervention for impingement syndrome when the injured worker has physical findings of significant activity limitations that are supported by an imaging study that has failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker has significant physical findings that have failed to respond to multiple conservative treatments. Although it is noted within the documentation that the injured worker underwent an MRI in November 20, 2013, this was not provided for review. Without an independent review of the injured worker's MRI, the necessity of surgical intervention cannot be determined. As such, the requested left shoulder scope with debridement is not medically necessary.

**INTERNAL MEDICINE FOR PRE-OPERATIVE CLEARANCE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, ,

**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.

**SLING: 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 OPERATIVE PHYSICAL THERAPY TWO TIMES PER WEEK FOR FOUR WEEKS: 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.