

<b>Case Number:</b>	CM14-0012540		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	12/12/2007
<b>Decision Date:</b>	07/09/2014	<b>UR Denial Date:</b>	01/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine, 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 patient is a 60-year-old gentleman who was injured on 12/12/07 sustaining injury to the left upper extremity. Recent clinical records include a 12/4/13 progress report indicating continued left shoulder tenderness and symptoms consistent with impingement. Physical examination showed positive impingement signs with flexion and abduction to 155. Due to continued complaints of pain that have failed conservative care, operative intervention in the form of arthroscopy was recommended for further intervention. Previous imaging includes a 4/10/12 MRI report showing fraying of the supraspinatus tendon with bursitis. There is no indication of recent imaging for review. While it states that the claimant has failed conservative care, specific conservative measures are not documented. There were also complaints in this case of underlying neck pain for which electrodiagnostic studies showed mild carpal tunnel entrapment. As stated, there is a request for surgical therapeutic and diagnostic arthroscopy to the shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **LEFT SHOULDER DIAGNOSTIC AND OPERATIVE ARTHROSCOPY: 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 rationale:** Based on California MTUS/ACOEM Guidelines, shoulder arthroscopy would not be indicated. While this individual is noted to be with inflammatory findings on MRI scan of 2012, there is no recent imaging or documentation of specific conservative care that would support the acute need of surgical intervention. Without documentation of 3-6 months of conservative care including injection therapy or updated imaging, the acute need of operative process would not be supported. The request for left shoulder diagnostic and operative arthroscopy is not medically necessary and appropriate.

**POSTOPERATIVE PHYSICAL THERAPY, LEFT SHOULDER, TWELVE SESSIONS:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

**PHYSICAL THERAPY, RIGHT ELBOW, TWELVE SESSIONS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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

**REQUEST FOR 60-DAY RENTAL THERMOCOOL HOT/COLD CONTRAST THERAPY WITH COMPRESSION:** 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 (ODG)-- Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: knee procedure - Game Ready accelerated recovery system.

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

**REQUEST FOR COMBOCARE 4 ELECTROTHERAPY:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Page(s): 118, 120, 121.

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

**REQUEST FOR 30-DAY RENTAL CPM:** 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 Treatment in Worker's Comp , 18th Edition, 2013 Updates: shoulder procedure - Continuous passive motion (CPM).

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

**REQUEST FOR ULTRASLING WITH 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: shoulder procedure - Postoperative abduction pillow sling.

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