

<b>Case Number:</b>	CM14-0121962		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	08/05/2011
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	07/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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 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 55-year-old female who was injured August 5, 2011. Records indicate this was due to repetitive job duties injuring her left shoulder. Recent clinical assessment for review of June 12, 2014 reveals continued pain about the left shoulder for which this individual is contemplating operative intervention. It states at that time that an MRI scan was reviewed showing AC joint degenerative change and bursitis, but no indication of labral or rotator cuff pathology. There is documentation of positive examination findings showing impingement, Neer and Hawkins testing, and full range of motion. Documentation of prior conservative care has included medications, physical therapy, and activity restrictions. There is a current request for surgery to include a left shoulder arthroscopy, subacromial decompression and exploration of the rotator cuff.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic surgery with subacromial decompressions and exploration of cuff.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (DG), Treatment Index, 11th Edition (web), 2013, Shoulder Chapter, Diagnostic arthroscopy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 211.

**Decision rationale:** Based on California ACOEM Guidelines, shoulder arthroscopy and decompression would not be supported. In regards to surgery for impingement, Guidelines indicate the role of conservative care for three to six months including corticosteroid injections before proceeding with operative procedure. In this case, there is no documentation of the claimant's formal imaging, nor indication of recent injectual therapy. Without documentation of the above, the request for surgical intervention to include a decompression and exploration of the claimant's rotator cuff would not be supported. The request is not medically necessary and appropriate.

**Pre-operative 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 med necessary, none of the associated services are medically necessary.

**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 med necessary, none of the associated services are medically necessary.

**Shoulder sling 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 cite any medical evidence for its decision.

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

**Post-operative physical therapy 2 times 4 weeks.:** 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 med necessary, none of the associated services are medically necessary.