

<b>Case Number:</b>	CM14-0038007		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	07/24/2012
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	03/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2014

### 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:

Claimant with reported industrial injury on 7/24/12 with injuries to the left shoulder, low back and neck. MRI left shoulder on 1/2/14 demonstrates report of Hill-sachs deformity with soft tissue Bankart lesion. Teninopathy is noted of the supraspinatus and subscapularis, but no mention of partial or full thickness tear. Mild AC joint arthrosis is noted. Exam note 2/14/14 demonstrates neck, back and left shoulder pain. Report of no improvement in symptoms with Advil, Tylenol with codeine. Exam demonstrates limited range of motion and positive impingement testing. Difficulty sleeping is reported secondary to pain in the left shoulder and lumbar spine. Objective findings include decreased ankle jerk and gastrocnemius strength and decreased sensation in the posterior lateral foot and heel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic subacromial decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Surgery for rotator cuff repair.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, Acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 2/14/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the cited notes do not demonstrate evidence satisfying the above criteria. Therefore the determination is not medically necessary.

**Shoulder 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Sprix nasal spray:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs).

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Postoperative prescription of Norco:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chronic Pain Treatment Guidelines Opioids (Criteria for use).

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Postoperative prescription of Duracef:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Postoperative prescription of Zofran:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Postoperative physical therapy for the left shoulder, 2 times per week for 4 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**8 sessions of Acupuncture therapy for the spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

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

**Decision rationale:** Per the MTUS Acupuncture Medical Treatment Guidelines, pages 8&9 Frequency and duration of acupuncture or acupuncture with electrical stimulation maybe performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments.(2) Frequency: 1 to 3 times per week.(3) Optimum duration: 1 to 2 months.(d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e).The guidelines specifically report 3-6 treatments initially. As the request is for 8 visits, the determination is not medically necessary.