

<b>Case Number:</b>	CM14-0041085		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	04/06/2013
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	03/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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 45-year-old female who sustained an injury to the right shoulder on April 8, 2013. The clinical records provided for review include the report of an MRI dated June 15, 2013 identifying mild rotator cuff tendinosis, an intact labrum and biceps tendon but no other findings. Electrodiagnostic studies that were performed in October 2013 were normal. The follow-up report of February 11, 2014 noted continued shoulder complaints and difficulty with overhead activities. Physical examination was documented to show full range of motion but with pain, tenderness over the subacromial arch, positive impingement sign but no documentation of weakness. The claimant was diagnosed with impingement syndrome and the recommendation for a subacromial decompression was made. The records document that prior conservative treatment included physical therapy and a corticosteroid injection that provided no significant benefit. The medical records do not identify any recent treatment for the claimant.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopy, subacromial decompression for right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-214. Decision based on Non-MTUS Citation Official Disability Guidelines, shoulder (updated 01/20/2014) Diagnostic: arthroscopy.

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

**Decision rationale:** Based on California ACOEM Guidelines, the request for right shoulder arthroscopy and subacromial decompression cannot be supported. The claimant's physical examination does not identify any weakness on examination. There is also no documentation of recent conservative care that has been utilized over past three to six months as recommended by the ACOEM Guidelines to support the acute need of operative intervention. While this individual had previously undergone an injection that took place in early 2013, the lack of documentation of recent conservative treatment and the claimant's current clinical presentation would not support the need for the proposed surgery as medically necessary.

**Postoperative physical therapy 3 times per week for 4 weeks #12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563, Postsurgical Treatment Guidelines.

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

**Decision rationale:** The request for right shoulder arthroscopy and subacromial decompression cannot be supported. Therefore, the request for twelve sessions of physical therapy is not necessary.

**Cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Shoulder (updated 01/20/2014) Continuous flow cryotherapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, 555-556.

**Decision rationale:** The request for right shoulder arthroscopy and subacromial decompression cannot be supported. Therefore, the request for use of a postoperative cryotherapy device is not necessary.