

<b>Case Number:</b>	CM14-0077874		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	10/28/2013
<b>Decision Date:</b>	11/13/2014	<b>UR Denial Date:</b>	05/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 51 year old male with an industrial injury dated 10/28/13. The medical records were reviewed. CT arthrogram of the left shoulder dated 04/10/14 demonstrates severe osteoarthritic change within the glenohumeral joint with severe joint space narrowing, subchondral sclerosis and extensive subchondral cystic changes, mainly at the posterosuperior aspect of the glenoid. In addition, it is noted that there is a low grade partial thickness tearing of the supraspinatus tendon. Exam note dated 04/15/14 states the patient returns with left shoulder pain. The patient explains that the pain is affecting his sleep and that the pain is progressing to be more constant. Upon physical exam it is noted that there is significant impingement of the left shoulder due to the large hypertrophic changes of the left shoulder joint. Diagnosis is noted as glenohumeral joint arthritis of the left shoulder. Treatment includes decompression with arthroscopy and arthrotomy approaches and debridement of the hypertrophic bony changes of the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopy, arthrotomy, decompression, debridement of large hypertrophic changes, left shoulder:** 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, TWC Shoulder Procedure Summary

**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) Shoulder, Acromioplasty surgery

**Decision rationale:** According to the California 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 Official Disability Guidelines 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 4/15/14. 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 exam note from 4/15/14 does not demonstrate evidence satisfying the above criteria except for night pain. Therefore, the request is not medically necessary.

**Inpatient admission for 1 day:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, TWC Shoulder Procedure Summary, Hospital Length of Stay Guidelines

**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.