

<b>Case Number:</b>	CM14-0078210		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	06/26/2012
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	05/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2014

### 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 28 years old with reported industrial injury on 6/26/12 with left shoulder pain. Exam note dated 4/25/14 demonstrates patient with continued left shoulder pain. Objective findings include pain with flexion of the left shoulder from 0-90 degrees with 3/5 flexion and abduction of the left shoulder. 0-45 degrees with 2/5 abduction strength is noted in the exam note. MRI arthrogram dated 5/7/14 demonstrates intact left rotator cuff status post debridement of the anterior labrum and intact biceps. Claimant is status post subacromial decompression with acromioplasty and release of the coracoacromial ligament and extensive glenohumeral debridement on 12/5/12.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy, debridement, biceps tendon repair (BTR), possible slap (superior labrum anterior and posterior) repair, open sub-acromial decompression (SAD), distal clavicle excision (DCE): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Indications for Surgery.

**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 Section, Acromioplasty.

**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 4/25/14. 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 4/25/14 does not demonstrate evidence satisfying the above criteria. In addition the MRI of the shoulder from 5/7/14 does not demonstrate an obvious surgical lesion. Therefore, this request is not medically necessary.

**Surgical Assistant:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

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

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

**Physical Therapy times twelve (12) visits left shoulder:** Upheld

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

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

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