

<b>Case Number:</b>	CM14-0083255		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	07/15/2003
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	05/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2014

### 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 patient is a 55-year-old male with industrial injury date of 07/15/2003. There is claim that the right shoulder complaint is compensatory to overuse because of his left shoulder issues. He is diagnosed with joint pain of the shoulder. The medical records indicate he has undergone multiple surgeries to the left shoulder, resulting in hemiarthroplasty. Treatment has also included medications. According to the 4/16/2014 progress report, the patient's complaint is bilateral shoulder pain. On examination of the right shoulder, he has signs and symptoms; he has anterior pain, positive O'Brien's, Yergasons and Speed's test. Range of motion is good and cuff strength is good. An open right shoulder magnetic resonance imaging (MRI) reportedly shows T2 changes within the acromioclavicular (AC) joint and superior labral tear from anterior to posterior (SLAP) lesion. Impression is right shoulder superior labral anterior posterior (SLAP) tear. Recommendation includes surgical intervention to the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopy, subpectoral repair, biceps tenodisis: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, SLAP Lesion Diagnosis.

**Decision rationale:** According to the CA MTUS ACOEM guidelines, surgical considerations depend on the working or imaging-confirmed diagnoses of the presenting shoulder complaint. Surgical referral may be indicated for patients who have activity limitation for more than four months, plus existence of a surgical lesion; failure to increase range of motion (ROM) and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. According to the 4/16/2014 progress report, the patient has good range of motion and rotator cuff strength in the right shoulder. The medical records do not provide current magnetic resonance imaging (MRI) study report of the right shoulder that clearly demonstrates the presence of a surgical lesion. Furthermore, the medical records do not detail a treatment history as it pertains to the compensatory right shoulder complaint. Essentially, the medical records do not establish the patient has significant and persistent subjective/objective findings with corroborative and correlating imaging findings, which have failed to respond to standard conservative measures, and likely to benefit from the proposed surgical intervention. The medical necessity of the request has not been established.

**Post-op Physical therapy 2x6:** 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 Page(s): 26-27.

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

**Inpatient stay x1-2 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Hospital length of stay (LOS).

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

**Post-op Durable Medical Equipment : Vascutherm cold therapy unit x30 day rental:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous-flow cryotherapy.

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

**Sling:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

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