

<b>Case Number:</b>	CM14-0084225		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	06/07/2010
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 injured worker is a 44-year-old female who was reportedly injured on June 7, 2010. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated March 28, 2014, indicated that there were ongoing complaints of shoulder pain and sleep hygiene issues. The physical examination was not presented. An additional evaluation noted complaints of neck pain, bilateral hand pain with numbness, low back pain, a tremor of the right hand (a noted to be non-physiologic). Diagnostic imaging studies objectified an intact rotator cuff of the right shoulder, degenerative changes in the acromioclavicular joint, and a central tear involving long-term the biceps tendon. The left shoulder noted an acromioclavicular joint. The rotator cuff was noted to be intact. Previous treatment included multiple evaluations and conservative care. A request was made for the left shoulder surgery and was not certified in the pre-authorization process on May 19, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy with distal claviclectomy including distal articular surface:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for surgery, partial claviclectomy.

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

**Decision rationale:** As noted in the California Medical Treatment Utilization Schedule, surgical intervention would require a rotator cuff tear and repair as being necessary. The magnetic resonance image, dated September 13, 2013, clearly establishes that there is no rotator cuff tear in either the left or right shoulder. With respect to impingement syndrome, there are minimal degenerative changes, but nothing that would warrant surgical intervention. As such, based on the clinical data provided, there is insufficient clinical evidence to support the surgery. This is not medically necessary.

**left shoulder arthroscopy with rotator cuff repair:** Upheld

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

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

**Decision rationale:** As noted in the California Medical Treatment Utilization Schedule, surgical intervention would require a rotator cuff tear and repair as being necessary. The magnetic resonance image dated, September 13, 2013 clearly established that there was no rotator cuff tear in either the left or right shoulder. With respect to impingement syndrome, there are minimal degenerative changes, but nothing that would warrant surgical intervention. As such, based on the clinical data provided, there is insufficient clinical evidence to support the surgery. This is not medically necessary.

**Post-operative Physical Therapy, qty unspecified:** 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 04/25/14), Physical Therapy.

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

**Decision rationale:** When noting that the underlying surgical request is not medically necessary, postoperative physical therapy is not medically necessary.

**Postoperative shoulder sling:** 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 04/25/14), Postoperative abduction pillow sling.

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

**Decision rationale:** When noting the underlying surgical request is not clinically indicated, a postoperative sling is not medically necessary.

**Cold therapy unit, rental or purchase unspecified, duration unspecified:** 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 04/25/14),, Continuous-flow cryotherapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**Decision rationale:** Cold therapy is indicated for knee disorders. There is no indication for shoulder surgery. Furthermore, the underlying surgical intervention is not considered medically necessary; either is this postoperative intervention.

**Left shoulder capsulorrhaphy, anterior, with labral repair:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, indications for surgery, Surgery for SLAP Lesions.

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

**Decision rationale:** As noted in the California Medical Treatment Utilization Schedule, surgical intervention would require a rotator cuff tear and repair as being necessary. The magnetic resonance image, dated September 13, 2013 clearly established that there is no rotator cuff tear in either the left or right shoulder. With respect to impingement syndrome, there are minimal degenerative changes, but nothing that would warrant surgical intervention. As such, based on the clinical data provided, there is insufficient clinical evidence to support the surgery. This is not medically necessary.