

<b>Case Number:</b>	CM14-0195149		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	01/10/2014
<b>Decision Date:</b>	01/29/2015	<b>UR Denial Date:</b>	10/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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 Minnesota. 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 49-year-old male with a history of left shoulder injury on 1/10/2014. Per examination of 10/14/2014 there was pain in the left shoulder and left elbow. Flexion was 140, extension 20, abduction 110 and adduction 0. External rotation was 90 and internal rotation 90. Impingement signs were positive. There was a crepitus with range of motion. MRI of the left shoulder dated 7/8/2014 revealed mild rotator cuff tendinosis without discrete partial or full-thickness tear. There was some hypertrophy of the acromioclavicular joint. There was an abnormal signal of the labrum anteriorly and superiorly as well as posterior inferiorly compatible with an old labral tear. There was mild irregularity of the articular cartilage of the glenohumeral joint but there was no full-thickness cartilaginous defect. The clinical diagnosis was impingement syndrome. Authorization was requested for arthroscopic debridement of the subacromial space of the left shoulder. There was no response to oral medications or a steroid injection. It was discovered that the injured worker had not been compliant with physical therapy in February. Utilization review noncertified the request for arthroscopy because of the absence of the necessary conservative treatment including corticosteroid injections and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Surgery Arthroscopic Debridement, Acromioplasty, Bursectomy For Left Shoulder:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, 213.

**Decision rationale:** The surgery for impingement syndrome is subacromial decompression. The California MTUS guidelines indicate 3-6 months of conservative treatment including physical therapy and corticosteroid injections prior to surgical considerations. The documentation provided indicates that physical therapy and corticosteroid injections have not been tried. Only one injection was given and the type of response has not been documented. The guidelines indicate 2- 3 subacromial injections of local anesthetic and cortisone preparation over an extended period of time as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. Diagnostic lidocaine injections to distinguish pain sources in the shoulder area, for example impingement, have also not been given. Based upon the absence of a comprehensive conservative treatment program, the request for arthroscopy with subacromial decompression and bursectomy of the shoulder is not supported and as such the Surgery Arthroscopic Debridement, Acromioplasty, Bursectomy For Left Shoulder is not medically necessary.

**Associated Surgical Service: Cephalosporin 250mg Quantity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, 213.

**Decision rationale:** The requested surgery is not medically necessary. Therefore the postoperative medications are also not medically necessary.

**Associated Surgical Service: Vicodin 5/500mg Quantity 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, 213.

**Decision rationale:** The requested surgery is not medically necessary. Therefore the postoperative medications are also not medically necessary.

**Associated Surgical Service: Occupational Therapy (OT), Post Operation Two Times A Week For Six Weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, 213.

**Decision rationale:** The requested surgery is not medically necessary. Therefore the ancillary services are also not medically necessary.

**Associated Surgical Service: Medical Clearance, Pre Operative Medical Evaluation With Appropriate Diagnostic and Laboratory Test; Including: Chest X-ray, Left Shoulder:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, 213.

**Decision rationale:** The requested surgery is not medically necessary. Therefore the ancillary services are also not medically necessary.