

<b>Case Number:</b>	CM15-0000051		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	05/30/2012
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery

### 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 was a 48 year old male, who sustained an industrial injury, May 30, 2012. The injured worker was suffering from left shoulder and right knee pain. The injured worker was diagnosed with left shoulder pain. The injured worker rated the pain with medication 4 out of 10 and without pain medication 6 out of 10; 0 being no pain and 10 being the worse pain. According to the progress note of May 1, 2014, the injured worker had had left shoulder arthroscopic surgery in July 2013 and again in November 2013 for a detached biceps tendon. The injured worker has injections to the left shoulder in the past. The injured worker had left shoulder physical therapy for strengthening and range of motion. The injured worker continues home exercise program. The treatment surgeon's impression diagnoses were left shoulder pain, left impingement, adhesive capsulitis and left rupture of the biceps tendon. On December 4, 2014, the UR denied authorization for left shoulder arthroscopy decompression surgery, 12 sessions of physical therapy and 1 polar sling. The denial was based on the ACOEM guidelines for Arthroscopic decompression, Shoulder complaints Postoperative Surgical Physical Therapy. The polar sling denial was based on the ODG guidelines for Shoulder (Acute & Chronic)

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy decompression surgery: Upheld**

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

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

**Decision rationale:** According to the CA 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 ODG 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 5/1/14. 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 5/1/14 does not demonstrate evidence satisfying the above criteria. Therefore the determination is for non-certification.

**12 physical therapy sessions:** 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.

**1 polar care 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 (Acute & Chronic)

**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.