

<b>Case Number:</b>	CM15-0004611		
<b>Date Assigned:</b>	01/15/2015	<b>Date of Injury:</b>	08/29/2012
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	12/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2015

### 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 is a 54 year old male who sustained an industrial injury on 08/29/2012. He sustained work injuries due to an assault. Diagnoses include status post left knee arthroscopy with partial meniscectomy, lumbar disc disease, lumbar disc disease, left knee osteoarthritis changes, right shoulder rotator cuff tear and cervical disc disease. Treatment to date has included medications, post-op physical therapy to the left knee; status post left knee arthroscopy, psychological counseling, and steroid injections. A physician progress note dated 12/04/2014 documents the injured worker complains of left knee and left shoulder pain and weakness. The injured worker has a positive Hawking sign for impingement with weakness with abduction testing of the left shoulder. Treatment requested is for Left shoulder arthroscopy, subacromial decompression, distal clavicle resection, synovectomy (Associated services) DVT prophylactic compression cuffs and Q-Tech cold therapy unit, and (Associated services) Post-op physical therapy 2 x 4.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy, subacromial decompression, distal clavicle resection, synovectomy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines - Shoulder Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Acromioplasty surgery.

**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 12/4/14. There is lack of conservative care from the records to support left shoulder arthroscopy with subacromial decompression and distal clavicle resection with synovectomy. Therefore the determination is for non-certification.

**(Associated services) Post-op physical therapy 2 x 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**(Associated services) DVT prophylactic compression cuffs and Q-Tech cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-309. Decision based on Non-MTUS Citation Official Disability Guidelines- Shoulder chapter, knee chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoudler, Compression Garments.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.