

<b>Case Number:</b>	CM15-0019881		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	04/19/2014
<b>Decision Date:</b>	04/10/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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: New York

Certification(s)/Specialty: Neurological 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:

This 58 year old male reported a repetitive use industrial injury on April 29, 2014 from buffering and polishing fiberglass tops for campers and trucks. The diagnoses have included muscle weakness, shoulder impingement/bursitis and osteoarthritis shoulder. Treatment to date has included diagnostic studies, medication, physical therapy and cortisone injections. Currently, the injured worker complains of an aching pain in the shoulders that radiated into his upper back. He reported popping in the left shoulder. The pain increased when reaching backwards and reaching above shoulder level. He also has increased pain when he is lying on his sides. Examination revealed a positive impingement. On January 20, 2015, Utilization Review non-certified (cont #1) acromioclavicular joint repair and associated procedures, (cont #2) left shoulder video arthroscopy-anterior subacromial decompression, 12 physical therapy, post op cold therapy unit, post op ARC sling, pre op EKG, pre op chest x-ray, pre op lab: CBC, CMP, PT, PTT, UA and pre op clearance, noting the Official Disability Guidelines. On February 2, 2015, the injured worker submitted an application for Independent Medical Review for review of (cont #1) acromioclavicular joint repair and associated procedures, (cont #2) left shoulder video arthroscopy-anterior subacromial decompression, 12 physical therapy, post op cold therapy unit, post op ARC sling, pre op EKG, pre op chest x-ray, pre op lab: CBC, CMP, PT, PTT, UA and pre op clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(Cont #1) Acromioclavicular joint repair & associated procedures: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter; Low Back - Lumbar.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter-Surgery for impingement.

**Decision rationale:** According to the ODG guidelines the indications for acromioplasty are failure of a treatment program directed toward gaining a full range of motion and improving strength. Documentation does not contain evidence of the patient's participation in such a program. In addition the physical examination should show evidence of pain on a arc of motion 90 to 130 degrees. The records do not contain such evidence. Muscle strength testing and range of motion data is not sufficient to meet the ODG guidelines for acromioplasty. Thus the requested treatment: (cont#1) Acromioclavicular joint repair & associated procedures is not medically necessary and appropriate.

**Left shoulder video arthroscopy-anterior subaromial decompression (Cont #2): Upheld**

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

**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.

**Associated surgical service: 12 physical therapy: Upheld**

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

**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.

**Post-operative Cold Therapy Unit: Upheld**

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

**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.

**Post-operative ARC sling:** Upheld

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

**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.

**Pre-operative EKG (electrocardiogram):** Upheld

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

**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.

**Pre-operative Chest X-ray:** Upheld

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

**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.

**Pre-operative lab: CBC, CMP, PT, PTT, UA:** Upheld

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

**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.

**Pre-operative clearance:** Upheld

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

**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.