

<b>Case Number:</b>	CM15-0146575		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	03/27/2000
<b>Decision Date:</b>	09/30/2015	<b>UR Denial Date:</b>	07/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2015

### 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, Oregon, Washington  
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 41 year old female, who sustained an industrial injury on 3-27-00. The injured worker has complaints of left shoulder pain. The documentation noted left shoulder tenderness acromioclavicular (AC) joint and anterior aspect. The diagnoses have included other affections of shoulder region, not elsewhere classified and sprains and strains of other specified sites of shoulder and upper arm. Treatment to date has included tylenol #3 and left shoulder X-rays on 12-14-12 showed status post left shoulder distal resection lateral third clavicle. The request was for 1 left shoulder arthroscopy with sub-acromial decompression; one medical clearance; one set of labs to include complete blood count, comprehensive metabolic panel, prothrombin time, partial thromboplastin time (PTT) and pregnancy; one ultrasling immobilizer; one cold therapy unit; one shoulder pulley system and theraband and post -operative physical therapy 8 sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy with sub-acromial decompression:** Upheld

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

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

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 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 6/30/15. 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 6/30/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the determination is not medically necessary.

**Associated surgical service: Medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 Edition pages 92-93.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical service: 1 set of labs to include CBC, CMP, PT/PTT, Preg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 Edition pgs 92-93.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical service: 1 Ultrasling immobilizer:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical service: 1 Cold therapy unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Continuous-flow cryotherapy.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical service: 1 Shoulder pulley system and theraband: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Post-operative physical therapy 8 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.