

<b>Case Number:</b>	CM15-0161922		
<b>Date Assigned:</b>	08/28/2015	<b>Date of Injury:</b>	01/02/2014
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	07/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/17/2015

### 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 64-year-old male who sustained an industrial injury on January 2, 2014 resulting in left shoulder pain. Diagnoses have included shoulder sprain, and left shoulder impingement. Documented treatment includes left shoulder steroid injection with 20 percent relief lasting 2 weeks, aquatherapy, and medication. The injured worker continues to present with left shoulder pain with impaired range of motion. The treating provider's plan of care includes left shoulder arthroscopy, possible decompression with acromioplasty, resection of the coraco-acromial ligament or bursa as indicated, and Mumford procedure; pre-operative clearance and urine toxicology testing; and, post-operative home health care including 6 hours per day for three days with dressing change once a day and assistance with activities of daily living; continuous passive motion unit, 30 day rental of DVT compression home unit with bilateral calf sleeve; and, 18 sessions of post-operative physical therapy for the left shoulder. Current work status is not available.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopy, Possible Decompression with Acromioplasty, Resection of Coraco-acromial Ligament or Bursa as Indicated, Mumford Procedure: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 210.

**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. 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. The medical documentation only shows a 20% relief of pain with injection. In this case the exam notes do not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is for non-certification. Based upon the CA MTUS Shoulder Chapter. Pages 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case the exam notes and the imaging findings do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the request is not medically necessary.

**Pre-Operative Medical 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. 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.

**Pre-Operative Urine Toxicology Testing:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. 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 Home Healthcare 6 Hours per Day for 3 Days, Dressing Change Once a Day, and Assistance of Daily Living Activities:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. 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: CMP Unit (duration & frequency unspecified):** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. 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.

**Postoperative DVT Compression Home Unit with Bilateral Calf Sleeve 30 day rental:**  
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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. 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.

**Postoperative Physical Therapy 3 x 6 left shoulder:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. 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.