

<b>Case Number:</b>	CM15-0162240		
<b>Date Assigned:</b>	08/28/2015	<b>Date of Injury:</b>	07/28/2011
<b>Decision Date:</b>	10/20/2015	<b>UR Denial Date:</b>	08/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2015

### 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: Montana, Oregon, Idaho  
 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 60 year old male, who sustained an industrial injury on 7-28-2011. He reported pain in his neck, extending down the left arm into the hand. He also reported back pain. Diagnoses have included status post left carpal tunnel release and left shoulder strain with continued left shoulder and periscapular soreness. Treatment to date has included physical therapy, magnetic resonance imaging (MRI), injections and surgery. According to the progress report dated 7-22-2015, the injured worker was doing well status post carpal tunnel release. He still complained of soreness around his neck. Physical exam revealed swelling on the left hand. His shoulder demonstrated pain with impingement signs and soreness mostly on the anterior aspect of the shoulder around the rotator interval. His left upper extremity was weak. Authorization was requested for left shoulder diagnostic arthroscopy, a simple sling and post-operative physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder diagnostic arthroscopy, debridement, possible rotator cuff, subacromial decompression, possible biceps tenodesis outpatient:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (<http://odg-twc.com/odgtwc/shoulder.htm>) - rotator cuff repair.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

**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. 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 notes from 4/29/15, 7/8/15 and 7/22/15 do not demonstrate evidence satisfying the above criteria. There is no documentation of a painful arc of motion, night pain or relief with an anesthetic injection. The MRI from 10/31/14 demonstrates post-surgical changes from previous distal clavicle resection with adequate decompression of the acromial arch and no lesion which would benefit from surgical treatment. Therefore the request is not medically necessary.

**Associated surgical service: simple sling:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

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

**Post-operative physical therapy 3 times a week for 4 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

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