

<b>Case Number:</b>	CM15-0209449		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	01/25/2014
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	10/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2015

### 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 56 year old male injured worker suffered an industrial injury on 1-25-2014. The diagnoses included right shoulder pain following arthroscopy 6-28-2014 and right carpal tunnel syndrome and cubital tunnel syndrome. On 10-2-2015, the provider reported moderate to severe intermittent pain in the right shoulder. Pain relief from the steroid injection last only 7 days. On exam, the right shoulder had positive Neer's test, positive Hawkin's test and positive arc of motion with tender joint tenderness. The provider noted the request for arthroscopy was based on a positive impingement test. Prior treatments included Tramadol and Diclofenac and steroid injection to the shoulder 8-26-2015. Diagnostics included 6-8-2015 fluoroscopic right shoulder arthrography degenerative changes to the labrum and mild to moderate rotator cuff tendinosis. Utilization Review on 10-23-2015 determined non-certification for Right shoulder arthroscopy with subacromial decompression with associated services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopy with subacromial decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.  
 Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder section, acromioplasty.

**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 10/2/15. 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 10/2/15 does not demonstrate evidence satisfying the above criteria. Therefore the determination is for not medically necessary.

**Post op vascu therm cold therapy:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder / Cold compression therapy.

**Decision rationale:** The requested medical procedure is not medically necessary and therefore the associated surgical services are not medically necessary.

**Post op physical therapy, 3 x 6 weeks, right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

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

**Decision rationale:** The requested medical procedure is not medically necessary and therefore the associated surgical services are not medically necessary.