

<b>Case Number:</b>	CM15-0028460		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	10/24/2007
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	02/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/16/2015

### 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  
 Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 68-year-old female who reported an injury on 10/24/2007. The mechanism of injury involved heavy lifting. The injured worker is currently diagnosed with left shoulder arthritis. On 01/08/2015, the injured worker presented for a follow-up evaluation with complaints of left shoulder pain, stiffness, loss of motion, and numbness/tingling. The injured worker has been previously treated with ice therapy, rest, and heat therapy. Upon examination, there was normal motor strength bilaterally, tenderness over the AC joint, 160 degree flexion, 180 degree abduction, 45 degree external rotation, and internal rotation to T10. X-rays obtained in the office revealed a type II acromion and moderate changes of the AC joint. Recommendations at that time included a left shoulder arthroscopy with possible excision and revision. A Request for Authorization form was submitted on 01/27/2015. The official MRI of the left shoulder was also submitted, documented on 11/12/2014, and revealed mild supraspinatus and infraspinatus tendinosis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopy, debridement, distal clavicle resection: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); ODG Treatment; Integrated Treatment/Disability Duration Guidelines, Shoulder Chapter.

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

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. In this case, there was no documentation of a significant functional limitation. There was no imaging evidence of a significant pathology. Additionally, there is no documentation of a recent exhaustion of conservative treatment. Given the above, the request is not medically appropriate at this time.

**Pre-Op Labs (CMP, CBC, PT, PTT):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); ODG Treatment; Integrated Treatment/Disability Duration Guidelines, Low Back Chapter.

**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-Op EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); ODG Treatment; Integrated Treatment/Disability Duration Guidelines, Low Back Chapter.

**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.

**Remedy Sling:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); ODG Treatment; Integrated Treatment/Disability Duration Guidelines, Low Back Chapter.

**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-Op Follow up visit in 90 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341.

**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-Op Physical Therapy:** Upheld

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

**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.

**Assistant Surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); ODG Treatment; Integrated Treatment/Disability Duration Guidelines, Low Back Chapter.

**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.