

<b>Case Number:</b>	CM15-0028574		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	04/08/2014
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### 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  
 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 46 year old female, who sustained an industrial injury on 04/08/2014. The diagnoses have included internal derangement left shoulder and internal derangement right knee. Noted treatments to date have included physical therapy, cortisone injection, and medications. Diagnostics to date have included MRI of the left shoulder on 09/02/2014 which showed mild to moderate acromioclavicular joint degenerative changes and tendinopathy changes of the supraspinatus and infraspinatus tendon without evidence of full thickness tear. In a progress note dated 12/04/2014, the injured worker presented with complaints of persistent pain in her left shoulder. The treating physician reported the injured worker inquired about possible surgical options as her symptoms are increasing and resulting in significant sleep difficulties. Utilization Review determination on 01/17/2015 non-certified the request for Left Shoulder Arthroscopy with Decompression, Mumford resection, and possible rotator cuff repair if deemed necessary intra-operatively, Medical Clearance with Internist, 12 Postoperative Sessions of Physical Therapy, and 1 Arm Sling citing Medical Treatment Utilization Schedule American College of Occupational and Environmental Medicine and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopy with Decompression, Mumford Resection and Possible Rotator Cuff Repair if deemed necessary intra-operatively: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery: Rotator Cuff Repair.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Arthroscopic surgery for osteoarthritis.

**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. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 12/4/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 12/4/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. There is no evidence of a rotator cuff tear from the MRI of 9/21/14. Therefore the determination is for non-certification for the requested procedure.

**Medical Clearance with Internist: 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, Page 92-93.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back, Preoperative testing.

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

**12 Post-Operative Sessions of Physical Therapy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The California Post-Surgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

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

**Arm Sling:** 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): 212-214.

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