

<b>Case Number:</b>	CM15-0044538		
<b>Date Assigned:</b>	03/16/2015	<b>Date of Injury:</b>	09/26/2013
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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 67-year-old male who reported an injury on 09/26/2013, with an unknown mechanism of injury. The patient's current diagnoses include left shoulder contusion/pain. Past treatment includes the use of acupuncture treatment, a cortisone injection, CMP devices, and medication. Pertinent diagnostic studies include an ultrasound dated 03/26/2014, which revealed left distal rotator cuff degeneration/fraying/edema/no distinct tear of retraction. There was left normal long head biceps tendon, and left normal glenoid labrum. There was also noted to be a left normal AC joint. There was no indication of past surgical histories. Subjective complaints include complaints of left shoulder pain. The physical examination dated 01/19/2015, indicates range of motion of the left shoulder was forward flexion at 135 degrees, extension at 40 degrees, abduction at 135 degrees, adduction at 40 degrees, external rotation at 90 degrees, and internal rotation at 60 degrees. There was noted tenderness to palpation of the left shoulder. Strength of the left shoulder was noted to 4/5, with a positive AC joint compression test. Current medications include Motrin. The treatment plan includes a left shoulder arthroscopic decompression, distal clavicle resection, labral and/or rotator cuff debridement, preoperative medical clearance, postoperative rehabilitative therapy, and associated surgical services for a CPM machine, a Surgi-Stim unit, and a cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic decompression, distal clavicle resection, labral and/or rotator cuff debridement:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM California Guidelines Plus-Web-based version.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 221.

**Decision rationale:** The CA ACOEM Guidelines state that this procedure is not indicated for patients with mild symptoms or those who have no activity limitation, conservative care including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. The clinical documentation submitted for review indicates that the patient has previously failed conservative therapy, although there was no indication of when the physical therapy was completed, and there was no documentation of the patient's functional abilities before and after treatment. Given the above, this request is not medically necessary.

**Preoperative 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Postoperative rehabilitative therapy to the 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: continuous passive motion (CPM):** 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Surgi-Stim unit:** 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Cold therapy unit:** 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.