

<b>Case Number:</b>	CM15-0081857		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	12/05/2005
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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 71-year-old female, with a reported date of injury of 12/05/2005. The diagnoses include left shoulder impingement syndrome. Treatments to date have included a left shoulder MRI that showed rotator cuff tendinitis. The orthopedic examination report dated 04/17/2015 indicates that the treating physician recommended the left shoulder arthroscopy two months prior. It was reported that the injured worker returned with no improvement in her symptoms. The physical examination showed normal strength of the left upper extremity, intact sensation in all dermatomes, and decreased left shoulder range of motion. The treating physician requested a left shoulder arthroscopy and post-operative physical therapy for the left shoulder. On 04/20/2015, Utilization Review (UR) denied the request for a left shoulder arthroscopy and post-operative physical therapy for the left shoulder. The UR physician noted that evidence of weeks-months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. It was also noted that since the surgery was not found medically necessary, the related request was no applicable.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Section, Acromioplasty Surgery.

**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 4/17/15. 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 4/17/15 does not demonstrate evidence satisfying the above criteria. Therefore, the request is not medically necessary.

**Post-Operative Physical Therapy (16-sessions, 2 times a week for 8 weeks for 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.