

<b>Case Number:</b>	CM14-0134428		
<b>Date Assigned:</b>	08/27/2014	<b>Date of Injury:</b>	06/28/2012
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	08/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant is a 53-year-old who sustained an injury to the left shoulder on 06/28/12. The clinical records provided for review did not contain any imaging reports. The progress report dated 06/17/14 documented that the claimant had failed conservative care including medication management, a corticosteroid injection, physical therapy, and home exercise but continued to have left shoulder symptoms. The objective findings on examination showed tenderness to palpation, negative drop arm testing, no instability, tenderness to palpation of the acromion, and 4/5 strength with resisted abduction. The working diagnosis was left shoulder impingement, acromioclavicular arthrosis, and labral tearing. The recommendation was made for left shoulder arthroscopy, subacromial decompression, a Mumford procedure, and labral evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder scope SAD, MUM, labrum evaluation:** 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): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Worker's Comp, Shoulder Procedure - Surgery for SLAP lesions.

**Decision rationale:** Based on the California ACOEM Guidelines and supported by the Official Disability Guidelines, the request for left shoulder scope, subacromial decompression, Mumford

Procedure, and labrum evaluation cannot be recommended as medically necessary. Unfortunately, there are no formal imaging reports for review in this case to support the current shoulder diagnosis. The lack of documentation of imaging reports prohibits clinical correlation between the claimant's imaging and physical examination findings to meet the guideline criteria. Therefore, the proposed surgery is not recommended as medically necessary.

**Assistant surgeon:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Milliman Care Guidelines 18th edition: assistant surgeon Assistant Surgeon Guidelines (Codes 29355 to 29901) CPT Y/N Description 29827 N Arthroscopy, shoulder, surgical; with rotator cuff repair.

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

**Post operative physical therapy QTY: 12:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

**Shoulder sling:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, Shoulder Procedure - Postoperative abduction pillow sling.

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

**Cold therapy unit:** 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): 201-205, 555-556.

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