

<b>Case Number:</b>	CM14-0135001		
<b>Date Assigned:</b>	08/29/2014	<b>Date of Injury:</b>	02/11/2012
<b>Decision Date:</b>	10/07/2014	<b>UR Denial Date:</b>	08/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2014

### 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, has a subspecialty in Orthopedic Sports Medicine and is licensed to practice in Texas. 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 injured worker is a 25 year old female who sustained an injury on 02/11/12 while carrying a box weighing between 25 and 30 pounds. The injured worker indicated the box started to fall resulting in an injury to the left shoulder. The injured worker also had been followed for complaints of pain in the left posterior cervical area with numbness in the left upper extremity. Prior electrodiagnostic studies were noted to be unremarkable on electromyogram studies. The injured worker did have an magnetic resonance image study of the left shoulder from 09/17/12 which was reported as unremarkable. The injured worker was seen on 07/22/14 with continuing complaints of left shoulder pain that was somewhat improved with medications. The injured worker was felt to be very stable at this evaluation. Medications did include anti-inflammatories, Neurontin, tramadol and Elavil. The injured worker did report some stomach upset with these medications. On physical examination there was noted loss of range of motion of the left shoulder with positive impingement signs. Spasms in the trapezius were noted. The report referred to magnetic resonance image studies showing evidence for possible impingement syndrome; however, no additional imaging was available for review. The injured worker reported only transient relief with subacromial injections in the left shoulder. The requested left shoulder arthroscopic decompression and debridement with excision of lateral clavicle with postoperative physical therapy for 8 sessions and assistant surgeon and hot/cold packs x 2 were all denied by utilization review on 08/01/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic decompression and debridement and excision of lateral clavicle:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**Decision rationale:** The injured worker has had persistent complaints of left shoulder pain despite medications and injections. The injured worker did have transient relief with subacromial injections only. The only imaging study available for review was from 2012 which was reported as unremarkable. No further imaging studies were available for review showing evidence regarding potential impingement in the left shoulder. There was also no imaging evidence of any substantial osteoarthritis at the acromioclavicular joint that would require excision of the lateral clavicle as recommended by guidelines. As the clinical documentation submitted for review did not provide sufficient objective evidence to meet guideline recommendations regarding the proposed procedures, this reviewer would not have recommended this surgical request as medically necessary.

**Post Op PT 8 sessions:** 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 Page(s): 27.

**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 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: American Association of Orthopaedics Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics

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

**Hot/Cold ice packs x2:** 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) Shoulder Chapter, Hot/Cold packs

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