

<b>Case Number:</b>	CM14-0143175		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	12/27/2012
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2014

### 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 Occupational Medicine 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 patient is a 53-year-old male who has submitted a claim for left shoulder periscapular strain, tendinitis, and impingement associated with an industrial injury date of 12/27/2012. Medical records from 08/14/2013 to 06/18/2014 were reviewed and showed that patient complained of left shoulder pain graded 7/10. Physical examination revealed tenderness over bicipital groove and posterior subacromial area, slightly decreased ROM, intact strength and sensation of left shoulder, and positive impingement test in the left shoulder. X-ray of left shoulder dated 03/21/2013 revealed minimal acromioclavicular degenerative joint disease. MRI of the left shoulder dated 08/14/2013 revealed mild osteoarthritis of glenohumeral joint and partial thickness tear of supraspinatus tendon. Treatment to date has included left shoulder cortisone injection (11/2013), physical therapy, acupuncture, TENS, and pain medications. Of note, there was documentation of some relief with left shoulder cortisone injection. There was no objective documentation of functional outcome with physical therapy, acupuncture, TENS, and pain medications. Utilization review dated 08/29/2014 denied the request for Left shoulder arthroscopic subacromial decompression, distal clavicle resection, and labral cuff debridement because the guidelines criteria have not been met. Utilization review dated 08/29/2014 denied the request for Pre-operative clearance, Continuous Passive Motion Qty: 45days, Cold therapy unit, Surgi- Stim Qty: 90days, Physical therapy Qty: 12visits because the requests were not applicable as the contemplated surgical procedure was denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic subacromial decomp, distal clavicle resect, and labral cuff debridement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG Shoulder Section, Surgery for Impingement Syndrome, Partial Claviclectomy (Mumford procedure), and Surgery for Rotator Cuff Repair

**Decision rationale:** CA MTUS ACOEM Practice Guidelines Chapter 9 supports surgical intervention for patients who have: (1) red flag conditions; (2) activity limitation for more than four months, plus existence of a surgical lesion; (3) failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; (4) clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term, from surgical repair. ODG states that criterion for partial claviclectomy should include severe degenerative joint disease of AC joint. In addition, ODG states that rotator cuff repair surgery indications should include a diagnosis of full-thickness rotator cuff tear in imaging studies. In this case, the patient complained of left shoulder pain. Physical exam findings revealed slightly decreased ROM, positive impingement test in the left shoulder, and intact strength and sensation of left shoulder. There were no red flag conditions based on physical exam findings to support the need for surgery. Moreover, there was no documentation of functional outcome from previous physical therapy visits to provide evidence of failure to improve with exercises. Furthermore, x-ray of the left shoulder was done on 03/21/2013 with results showing minimal AC degenerative joint disease. A CA MTUS criterion for distal clavicle resection is degenerative AC joint disease. Lastly, MRI of the left shoulder was done on 08/14/2013 which showed a partial thickness tear of supraspinatus tendon. The patient did not meet the guideline criteria of full thickness rotator cuff tear to support the need for surgery. The patient has not met the guidelines criteria for shoulder surgery. Therefore, the request for Left shoulder arthroscopic subacromial decomp, distal clavicle resect, and labral cuff debridement is not medically necessary.

**Pre operative 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.

**Continuous Passive Motion Qty: 45days:** 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.

**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.

**Surgi- Stim Qty: 90days:** 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.

**Physical therapy Qty: 12visits:** 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.