

<b>Case Number:</b>	CM14-0144820		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	01/30/2014
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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:

This claimant is a 56-year old female who sustained an injury to her right upper extremity in a work-related accident on 01/30/14. The report of an assessment on 08/08/14 noted continued complaints of right shoulder pain and documented that a prior MRI arthrogram showed partial thickness, rotator cuff tearing, acromial clavicular osteoarthritis and signal change to the labrum. Physical examination showed diminished range of motion with pain, tenderness to palpation diffusely and primarily over the right bicep tendon, motion to 60 degrees of forward flexion, 50 degrees of abduction and a positive cross body and Yergason's test. As the claimant had failed conservative care, the recommendation was made for shoulder arthroscopy and preoperative medical clearance, purchase of a cryotherapy device and abduction sling. Formal documentation of conservative measures since time of injury was not in the records. This specific request for surgery is for "arthroscopic shoulder surgery".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic Shoulder Surgery:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidance, Rotator Cuff Repair

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 201-205, 555-556. Decision based on Non-MTUS Citation ACOEM, Chapter 7 Independent Medical Examinations and Consultations, page 127 and Official Disability Guidelines (ODG); Chapter Shoulder: Surgery for SLAP lesions.

**Decision rationale:** Based on the California ACOEM Guidelines and supported by the Official Disability Guidelines, The surgical request in this case is too vague and only describes a "shoulder arthroscopy" with no particular components of the procedure identified. While there is evidence of imaging demonstrating a signal change to the labrum and undersurface rotator cuff tear, there is no formal documentation in the medical records of six (6) months of conservative measures including injection therapy having been performed. Without the documentation as described above, the claimant does not meet the guideline criteria for surgery. It should be indicated that operative process in this case was not clearly defined. There would also be no indication for medical clearance or cryotherapy device. Therefore, the request for Arthroscopic Shoulder surgery is not medically necessary and appropriate.

**Abduction Sling:** 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.

**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.

**Purchase of Cold Therapy Unit (CTU) with Pad:** 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.