

<b>Case Number:</b>	CM14-0185635		
<b>Date Assigned:</b>	11/13/2014	<b>Date of Injury:</b>	08/11/2014
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	10/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2014

### 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:

According to the records made available for review, this is a 48-year-old female with an 8/11/14 date of injury. At the time (9/12/14) of request for authorization for associated surgical service: cold therapy unit 7 days rental, associated surgical service: surgery assistant surgeon, left shoulder arthroscopy debridement subacromial decompression, and associated surgical service: post-op physical therapy 2 times 6, there is documentation of subjective (severe left shoulder pain worse at night) and objective (tenderness over left trapezius, positive Hawkin's as well as Neer's sign, and decreased left shoulder range of motion) findings, imaging findings (MRI left shoulder (9/2/14) report revealed moderate rotator cuff tendinopathy with bursitis, acromioclavicular joint degenerative change, and a SLAP lesion), current diagnoses (bilateral shoulder sprain and left shoulder rotator cuff rupture/impingement), and treatment to date (physical therapy and medications). Regarding left shoulder arthroscopy debridement subacromial decompression, there is no documentation of clinical finding (weak or absent abduction; atrophy and tenderness over rotator cuff or anterior acromial area); and failure of additional conservative treatment (cortisone injections and temporary relief of pain with anesthetic injection (diagnostic injection test).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: cold therapy unit 7 days rental: 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.

**Associated surgical service: surgery 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 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.

**Left shoulder arthroscopy debridement subacromial decompression:** 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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Subacromial Decompression and Manipulation under Anesthesia

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder sprain and left shoulder rotator cuff rupture/impingement. In addition, given documentation of subjective (left shoulder pain worse at night) and objective (positive Hawkins' as well as Neer's impingement sign) findings, there is documentation of subjective and objective clinical findings. Furthermore, given documentation of imaging (MRI of left shoulder identifying moderate rotator cuff tendinopathy with bursitis, acromioclavicular joint degenerative change, and a SLAP lesion) findings, there is documentation of imaging clinical findings showing positive evidence of deficit in rotator cuff. Lastly, there is documentation of failure of conservative treatment (physical therapy and medications). However, there is no documentation of additional clinical finding (weak or absent abduction; atrophy and tenderness over rotator cuff or anterior acromial area); failure of additional conservative treatment (cortisone injections and temporary relief of pain with anesthetic injection (diagnostic injection test)). Therefore, based on guidelines and a review of the evidence, the request for left shoulder arthroscopy debridement subacromial decompression is not medically necessary.

**Associated surgical service: post-op physical therapy 2 times 6:** 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.