

<b>Case Number:</b>	CM14-0029512		
<b>Date Assigned:</b>	03/19/2014	<b>Date of Injury:</b>	11/08/2010
<b>Decision Date:</b>	05/20/2014	<b>UR Denial Date:</b>	02/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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:

The patient is a 46-year-old who injured her bilateral shoulders and left upper extremity in a work related accident on November 8, 2010. Specific to the patient's left shoulder, the clinical records provided for review included an MRI report of April 27, 2012 showing hypertrophic changes to the acromioclavicular joint with no rotator cuff or labral pathology. There was mild impingement of the distal supraspinatus tendon. A PR2 report dated February 5, 2014 indicated continued complaints of bilateral shoulder pain. Specific to the left shoulder, there was noted to be a positive Neer and Hawkins testing, positive Yergason testing and diminished motion to 90 degrees of flexion with pain. Weakness was noted for grip strength of the left hand but no documented weakness at the shoulder was noted. The diagnosis was symptomatic impingement syndrome. Surgery in the form of an arthroscopy with subacromial decompression, and possible rotator cuff repair was recommended. Although the documentation indicated that the patient failed conservative measures, there was no documentation of specific treatment including injection therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRE-OP 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 left shoulder surgery is not medically necessary, none of the associated services are medically necessary or appropriate.

**SYNVECTOMY & DEBRIDEMENT:** 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 left shoulder arthroscopy and possible mini open subacromial decompression is not medically necessary, none of the associated services are medically necessary or appropriate.

**LEFT SHOULDER ARTHROSCOPY POSSIBLE MINIOPEN WITH SAD:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, pages 560-561

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

**Decision rationale:** The Shoulder Complaints Chapter of the ACOEM Practice Guidelines do not recommend the proposed surgery for left shoulder arthroscopy and subacromial decompression as medically necessary. The Shoulder Complaints Chapter of the ACOEM Practice Guidelines also recommend three to six months of failed conservative care including injection therapy prior to proceeding with surgery for impingement. In this instance, there is no documentation of recent injection therapy. The request for left shoulder arthroscopy with possible miniopen with SAD is not medically necessary or appropriate.

**POSSIBLE ROTATOR CUFF REPAIR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, pages 560-561

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

**Decision rationale:** The Shoulder Complaints Chapter of the ACOEM Practice Guidelines do not recommend rotator cuff repair for this individual. There is no documentation within the records provided of imaging reports identifying rotator cuff pathology. The lack of documentation of a partial or full thickness rotator cuff tear would not support this portion of the

surgical process requested. The request for a possible rotator cuff repair is not medically necessary or appropriate.