

<b>Case Number:</b>	CM13-0065089		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	08/26/2013
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	11/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

At the time of the injury, the injured worker was a 32-year-old male who complained of right shoulder pain more than left. The date of injury is 8/26/2013. The mechanism of injury was from lifting a TV. An MRI scan of the right shoulder dated 3/30/2013 revealed a thin linear increased smooth signal between the anterosuperior labrum and the glenoid rim, which may represent a normal variant sub-labral recess rather than a labral tear. The rotator cuff was intact. Mild degenerative changes of the right acromioclavicular joint and a mild downsloping of the acromion was noted. The provider requested arthroscopy of the right shoulder with repairs as needed. This was noncertified by utilization review on November 12, 2013 citing ODG guidelines. The reason for the denial was lack of objective evaluations submitted for the patient with orthopedic testing and treatment history indicating that conservative measures had not been undertaken prior to the request for surgery. Based on the indication that the patient had a lack of objective findings to support the recommendation for surgery, the request for right shoulder arthroscopy was not supported. Physical therapy notes dated 8/30/2013 documented low back pain and shoulder blade pain, with right posterior thigh paresthesias. The diagnosis was acute lumbosacral strain. No Physical Therapy to the shoulder was documented. The documentation from 9/25/2013 indicates 80-85% improvement in the low back pain with functional mobility and pain management. The Utilization Review denial is appealed to this Independent Medical Review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A Right Shoulder Scope with Repairs as needed: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 211.

**Decision rationale:** California MTUS guidelines indicate surgical considerations for acute rotator cuff tears in young workers, activity limitation for more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term from surgical repair. The injured worker did not have a rotator cuff tear or evidence of impingement. The only finding on the MRI scan pertained to what the radiologist felt was a normal variant and not a labral tear. This did not represent an indication for arthroscopy. The documentation provided did not include evidence of a comprehensive exercise rehabilitation program with corticosteroid injections prior to the surgical request. In fact, there was no physical therapy for the shoulder documented. The physical therapy notes indicate that the reported injury of 8/26/2013 was primarily to the lower back. Based upon the above, the guidelines criteria had not been met and the request for arthroscopy of the right shoulder with repairs as needed was not supported and as such, the medical necessity of the request was not substantiated.

**Assistant PA-C: 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: Physical Therapy (3-times a week for 4-weeks for the right shoulder): 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

**Ultra Sling Right Shoulder:** 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