

<b>Case Number:</b>	CM14-0210083		
<b>Date Assigned:</b>	12/23/2014	<b>Date of Injury:</b>	09/24/2014
<b>Decision Date:</b>	03/09/2015	<b>UR Denial Date:</b>	12/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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. 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 injured worker is a 30-year-old male who reported an injury on 09/24/2014. While he was moving 60 pound objects from a flat to a pallet, he felt a pop in the right shoulder. A right shoulder x-ray performed on 09/29/2014 was unremarkable. An MRI performed on 11/05/2014 revealed postsurgical change in the labrum with anchors, and no re-tear of the labrum, distal clavicle resection and no cuff tear. On 11/20/2014, the injured worker presented for follow-up and had complaints of worsening pain due to lifting at work. He had an arthroscopic left anterior superior posterior labral repair done on 08/25/2009. Previous medications included Flexeril and meloxicam. No prior injections or physical therapy noted. Diagnoses were lumbosacral sprain to low back, arthralgia of the shoulder, right glenoid labral repair, right shoulder SLAP lesion, postsurgical after care obesity, right shoulder internal impingement, and right shoulder sprain. Examination of the bilateral shoulder revealed painful arc range of motion and an audible squeaking with active range of motion. There was decreased range of motion and tenderness to palpation over the biceps. There was a positive Neer's and Hawkin's tests. The treatment plan included a shoulder arthroscopy surgery. There was no rationale provided. The Request for Authorization form was dated 11/25/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Shoulder Arthroscopy/Surgery:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Shoulder - Biceps Tenodesis

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chapter 9, Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Diagnostic Arthroscopy.

**Decision rationale:** The request for shoulder arthroscopy surgery is not medically necessary. The CA MTUS/ACOEM Guidelines state that a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitations 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 for surgical repair. The Official Disability Guidelines do further state that an arthroscopy is indicated when imaging is inconclusive and acute pain or functional limitations continue despite conservative care. Shoulder arthroscopy should be performed in an outpatient setting. The information submitted for review should also specify if the patient had participated in previously recommended conservative treatment to include physical therapy, medications, and injections. The patient is noted to have decreased range of motion and complaints of pain. However, without evidence of the patient's failure to respond to conservative treatment prior to surgical intervention, medical necessity has not been established.