

<b>Case Number:</b>	CM14-0211042		
<b>Date Assigned:</b>	12/23/2014	<b>Date of Injury:</b>	10/01/2013
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2014

### 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 58-year-old female who reported an injury on 10/01/2013. The mechanism of injury was reportedly when she was carrying buckets of ice and felt a sharp pain in the injured worker left shoulder. The surgical history was non-contributory. The diagnoses include other affections in the shoulder region and sprain of the shoulder/arm. The prior therapies were noted to include acupuncture, TENS unit, medications, physical therapy, and topical medications. The diagnostic studies included an official MRI of the left shoulder, performed on 03/30/2014, which was noted to reveal supraspinatus tendinosis, infraspinatus radicular surface partial tendon tear, posterior glenoid labral tear, glenohumeral joint osteoarthritis with possible superimposed AVN of the humeral head, AC joint osteoarthritis, and subacromial/subdeltoid bursitis. On 10/24/2014, the injured worker had complaints of neck and left shoulder pain and weakness. Upon physical examination, the injured worker had limited range of motion to the injured worker left shoulder measuring forward flexion was from 0 to 150 degrees, external rotation was from 0 to 30 degrees, and internal rotation was to T12. It was indicated the injured worker had a positive O'Brien's sign. The treatment plan was noted to include an arthroscopy with subacromial decompression and labral repair, left shoulder due to persistent pain and clinical exam findings. The Request for Authorization was signed 10/24/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopy with subacromial decompression and labral repair, left shoulder: 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), Shoulder Chapter, Surgery for Impingement Syndrome; Indications for Surgery --Acromioplasty

**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, Diagnostic arthroscopy, Surgery for impingement syndrome, Surgery for SLAP lesions

**Decision rationale:** The American College of Occupational and Environmental Medicine guidelines indicate that surgical intervention may be appropriate for those who have red flag conditions, activity limitation for more than 4 months, failure to increase function despite exercise programs, and clear clinical and imaging evidence. Additionally, surgery for impingement syndrome is usually arthroscopic decompression and it is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, should be carried out for at least three to six months before considering surgery. The Official Disability Guidelines indicate the criteria for surgery for SLAP lesions is documentation noting 3 months of conservative treatment, and history and physical examination of imaging indicating the pathology. The clinical documentation submitted failed to indicate that the injured worker had objective impingement signs. The MRI revealed a posterior glenoid labral tear, which would support a SLAP lesion repair and the injured worker had glenohumeral joint osteoarthritis with possible superimposed AVN of the humeral head and a type II acromion, which would support findings of impingement on MRI. There was documentation that the injured worker had a positive O'Brien's test. There was a lack of documentation of a failure of conservative care including cortisone injections. As such, the request for arthroscopy with subacromial decompression and labral repair, left shoulder is not medically necessary.

**Associated surgery services: Post-op physical therapy 2 x 4 weeks for left shoulder: 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), Shoulder Chapter, Surgery for Impingement Syndrome; Indications for Surgery --Acromioplasty

**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 surgery service: Post-op deep vein thrombosis compression cuffs: 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), Shoulder Chapter, Surgery for Impingement Syndrome; Indications for Surgery --Acromioplasty

**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 surgery services: Post-op Q-tech cold therapy unit:** 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), Shoulder Chapter, Surgery for Impingement Syndrome; Indications for Surgery --Acromioplasty

**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 surgery services: Medical clearance:** 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), Shoulder Chapter, Surgery for Impingement Syndrome; Indications for Surgery --Acromioplasty

**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.