

<b>Case Number:</b>	CM14-0214821		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	10/29/2005
<b>Decision Date:</b>	03/04/2015	<b>UR Denial Date:</b>	11/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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

### CLINICAL CASE SUMMARY

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

52-year-old male with reported industrial injury of October 29, 2005, Exam note August 25, 2014 demonstrates tenderness over the long head of the biceps tendon and bicipital groove, No tenderness over the anterior aspect of the acromion or acromioclavicular joint. The patient is status post a stir injection in May 2014 which resulted in a severe reaction requiring an emergency room visit. A positive speed test is noted and negative impingement tests are noted. Request is made for left shoulder arthroscopic biceps tendon release an arthroscopic chondroplasty and debridement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Left shoulder resection, arthroscopic rotator cuff debridement & arthroscopic coracoplasty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, Acromioplasty surgery

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 8/25/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 8/25/14 does not demonstrate evidence satisfying the above criteria. Therefore the determination is for non-certification.

**Retrospective Associated surgical service: 10cc Marcaine with epinephrine injection:**  
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): 204.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.