

<b>Case Number:</b>	CM15-0008287		
<b>Date Assigned:</b>	01/23/2015	<b>Date of Injury:</b>	04/25/2013
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2015

### 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: New York, New Hampshire, Washington  
 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:

The injured worker is a 35 year old male, who sustained an industrial injury on April 25, 2013. He has reported left shoulder pain. The diagnoses have included shoulder and neck pain, depression, insomnia, left rotator cuff impingement, acromioclavicular joint arthrosis and superior labral tear and status post arthroscopic distal clavicle excision. Treatment to date has included physical therapy, injection, left shoulder partial thickness tear repair and debridement, electromyogram, nerve conduction velocity (NCV) and oral medication. Currently, the IW complains of left shoulder tenderness and weakness. Treatment includes magnetic resonance imaging (MRI) and X-ray. On January 7, 2015 utilization review non-certified a request for left shoulder acromioplasty revision Mumford, possible labral repair, possible biceps tenodesis, possible RCR, post-operative labs-CBC/CMP, post-operative cold therapy unit purchase, post-operative immobilizer purchase and post-operative physical therapy 12 visits. The Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM) guidelines and Official Disability Guidelines (ODG) were utilized in the determination. Application for independent medical review (IMR) is dated January 13, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Acromioplasty Revision Mumford, Possible Labral Repair, Possible Biceps Tenodesis, Possible RCR: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for SLAP Lesions

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-220.

**Decision rationale:** 35 yo male with chronic shoulder pain. The patient already had arthroscopic distal clavical excision. MTUS criteria for additional shoulder surgery not met. There is no clear correlation between MRI imaging and physical exam findings. There is no significant loss of motion on physical exam. There is no documentation of complete rotator cuff tear. MTUS criteria for shoulder surgery not met.

**Pre-Operative Labs - CBC/CMP: 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), Low Back. Preoperative Testing

**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.

**Post-Operative Cold Therapy Unit (purchase): 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, Continuous-flow cryotherapy

**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.

**Post-Operative Immobilizer (purchase): Upheld**

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

**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.

**Post-Operative Physical Therapy (12 visits):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**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.