

<b>Case Number:</b>	CM15-0118661		
<b>Date Assigned:</b>	06/26/2015	<b>Date of Injury:</b>	09/18/2014
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2015

### 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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 32 year old male who sustained an industrial injury on 10/18/14. He had complaints of left shoulder pain and was diagnosed with rotator cuff syndrome. Treatments to date include medications, physical therapy, arm sling, cortisone injections and surgery. Orthopedic shoulder consultation dated 12/8/14 reports continued left shoulder pain despite conservative treatments. Diagnosis is industrial left shoulder aggravation of glenohumeral arthrosis with impingement and partial thickness rotator cuff tear. Work status: not permanent and stationary, restrictions include no lifting greater than 20 pounds, limited pulling and pushing with left upper extremity and no overhead work with left upper extremity. Plan of care includes: outpatient left shoulder arthroscopy with arthroscopic debridement and subacromial decompression, postoperative physical therapy 2 times per week for 4 weeks and postoperative cold therapy unit and sling.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient arthroscopy and subacromial decompression of left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 210.

**Decision rationale:** According to the California MTUS/ACOEM, surgical considerations for the shoulder include failure of 4 months of activity modification and existence of a surgical lesion. In addition, the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The injured worker has failed conservative care, had surgery in January 2015 with poor response, and has failed post-surgical therapy and activity modification to date. However, there are no recent imaging studies submitted that clearly demonstrate a surgical lesion despite signs of impingement syndrome on examination, with painful range. As such, the request is not medically necessary at this time.

**Post op physical therapy 2x6 for the left 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.

**Associated surgical service: CBC, CMP, UA:** 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: EKG:** 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: Chest X-ray:** 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: Anesthesiologist consultation:** 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.