

<b>Case Number:</b>	CM15-0125432		
<b>Date Assigned:</b>	07/10/2015	<b>Date of Injury:</b>	12/11/2013
<b>Decision Date:</b>	09/14/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/29/2015

### 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, Indiana, Oregon  
 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 31 year old female, who sustained an industrial injury on 12-11-2013. The medical records indicated cumulative injuries to the neck and right shoulder. Treatments to date include activity modification, anti-inflammatory, analgesic, physical therapy, acupuncture treatments, and cortisone injections. Currently, she complained of pain rated 7-8 out of 10 VAS. On 3-30-15, the physical examination documented right shoulder tenderness, decreased range of motion, decreased sensation, and positive impingement tests. The treating diagnoses included ultrasound-confirmed impingement syndrome of the right shoulder. The plan of care included requests to authorize right shoulder arthroscopy, subacromial decompression, distal clavicle resection and labral debridement and-or repair, and associated services included pre-operative medical clearance, twelve post-operative physical therapy sessions, home continuous passive motion (CMP) device rental for 45 days, shoulder immobilizer with abduction pillow for purchase, surgi-stim unit rental for 90 days and coolcare cold therapy unit for purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic evaluation, arthroscopic right shoulder subacromial decompression, distal clavicle resection and labral debridement and/or repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, 209, 211, 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Surgery for impingement syndrome; Indications for Surgery-Acromioplasty; Partial claviclectomy (Mumford procedure); Surgery for shoulder dislocation; SLAP lesion diagnosis; Surgery for SLAP lesions.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** 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. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. In this case there is insufficient evidence to warrant labral repair secondary to lack of imaging characterization of the type of labral tear. Therefore request is not medically necessary.

**Pre-operative Medical Clearance:** 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.

**Supervised Post-Operative Rehabilitative Therapy 3 x 4:** 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: Home Continuous Passive Motion (CPM) Device Rental for 45 days:** 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: Shoulder Immobilizer with Abduction Pillow for Purchase:** 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: Surgi-Stim Unit Rental for 90 Days:** 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: Coolcare Cold Therapy Unit for Purchase:** 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.