

<b>Case Number:</b>	CM15-0021264		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	01/19/2006
<b>Decision Date:</b>	04/09/2015	<b>UR Denial Date:</b>	01/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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  
 Certification(s)/Specialty: Neurological 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 36-year-old male, who sustained an industrial injury on 1/19/2006. He reports left shoulder injury after a motor cycle accident. Diagnoses include left shoulder degenerative joint disease. Treatments to date include shoulder arthroscopic debridement, steroid injections, physical therapy and medication management. A progress note from the treating provider dated 12/10/2014 indicates the injured worker reported left shoulder pain. On 1/12/2015, Utilization Review non-certified the request for partial let shoulder replacement with decompression of peri labral cyst and suprascapular nerve decompression and distal clavicle resection, medical clearance, ultra sling, TENS (transcutaneous electrical nerve stimulation), 2 weeks vascultherm unit and 12 weeks of post-operative physical therapy to the left shoulder, citing MTUS, ACOEM and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Partial left shoulder replacement with decompression of the peri-labral cyst and suprascapular nerve decompression, distal clavicular resection: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203,-209.

**Decision rationale:** The California MTUS guidelines recommend a home exercise program as part of the initial care of shoulder injuries. Documentation does not describe any details about such a program. Outcomes following cortisone injections in the recent past similarly are not found. Thus a program of conservative care would be expected to be completed and an assessment of the increase in strength prior to consideration of a shoulder replacement. The requested treatment: 1 partial left shoulder replacement with decompression of the peri-labral cyst and suprascapular nerve decompression, distal clavicular is not medically necessary and appropriate.

**1 Medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Official Medical Fee Schedule pages 92-93.

**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.

**1 Ultra sling:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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.

**1 TENS Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**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.

**2 Weeks of vascutherm unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for clinical systems improvement.

**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.

**12 Weeks course of post op physical therapy to the left shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Medical fee schedule.

**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.