

<b>Case Number:</b>	CM15-0042381		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	09/23/2014
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 20-year-old female who reported injury on 09/23/2014. Her mechanism of injury was lifting. Her diagnoses included other affections of shoulder region, not elsewhere classified. Her past treatments included cortisone injection. Her diagnostic studies included an x-ray of the shoulder performed on 09/24/2014 that revealed no acute findings. An MRI of the right upper extremity was performed on 12/01/2014 and noted to reveal a minimal signal abnormality within the distal supraspinatus and infraspinatus tendons, compatible with mild tendinosis and/or strain, but no significant partial or full thickness tear, mild subacromial / subdeltoid bursitis, and a small focal linear pattern tear involving the glenoid labrum with the posterior superior quadrant. Her surgical history was not included. The injured worker had complaints of pain to the shoulder rated at a 6/10, stated she was having trouble with overhead activity, and pain sleeping on the shoulder. On physical exam, it was noted the injured worker had tenderness over the greater tuberosity and subacromial space. There was also tenderness anteriorly. There was restricted range of motion. There was flexion to the right at 160 degrees and to the left at 180 degrees. Extension was 50 degrees bilaterally. Abduction was 160 degrees to the right and 180 degrees to the left. Adduction was 50 degrees bilaterally. Internal rotation was 60 degrees to the right and 90 degrees to the left. External rotation was 60 degrees to the right and 90 degrees to the left. There was a positive Hawkins, Neer's, and O'Brien's test. Her medications were not included. Her treatment plan was not included in the medical record. The rationale for the request was not included in the medical record. The Request for Authorization form was not included in the medical record.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Shoulder Immobilizer:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Cold Therapy Unit:** 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.

**Right Shoulder Arthroscopy with Subacromial Decompression and Anterior Labral Repair:** 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), Treatment Index, 11th Edition (web), 2014, Shoulder, Immobilization.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for Impingement Syndrome.

**Decision rationale:** The request for a Right Shoulder Arthroscopy with Subacromial Decompression and Anterior Labral Repair is not medically necessary. There was a lack of documentation regarding attempt at any conservative care other than cortisone injections for the last 3 to 6 months. Therefore, the request is not medically necessary.

**Pain Pump:** 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.