

<b>Case Number:</b>	CM15-0044713		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	04/24/2002
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	02/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2015

### 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 60-year-old male who reported an injury on 04/24/2002. The mechanism of injury was reported when he was lifting a heavy transmission, which fell on him. His diagnoses include degenerative disc disease of the cervical region, degenerative disc disease of the lumbar region, and degenerative joint disease. Past treatments were noted to include medications. An unofficial MRI indicated the injured worker had non-displaced contrast imbibing the superior glenoid labral tear in a SLAP 2C configuration, AC joint arthrosis, and mild tendinosis of the supraspinatus tendon distally about the footplate without evidence of rotator cuff macro tear. Surgical history included right shoulder surgery x2. On 02/10/2015, it was noted the injured worker had right shoulder pain. He reported difficulty sleeping and engaging in activities secondary to pain. Upon physical examination, it was noted the injured worker had tenderness over the right shoulder with decreased range of motion measuring flexion at 100 degrees and abduction at 120 degrees. The injured worker had decreased motor strength, noting 4/5 to the right side, and his sensation was reduced. Upon physical examination on 03/03/2015, it was noted the injured worker had positive impingement, Neer's, and Hawkins tests. Medications included Norco, Soma, naproxen, metformin, Lyrica, atorvastatin, and Atenolol. The treatment plan was noted to include cervical and lumbar epidural steroid injections, medications, and physical therapy. A request was received for right shoulder arthroscopy, subacromial decompression, SLAP tear repair of the glenoid labrum, and possibly full excision of distal clavicle and Mumford procedure; postoperative physiotherapy 3 times per week for 4 weeks, right shoulder; postoperative acupuncture 2 times weekly for 6 weeks, right shoulder; DME (durable medical equipment) shoulder abduction pillow brace, micro cool; IFC (interferential) unit and supplies; TENS (transcutaneous electrical nerve stimulation) unit with supplies; exercise kit; and motorized compression pump, without a rationale. A Request for

Authorization was not provided.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right Shoulder Arthroscopy, Subacromial Decompression, SLAP Tear Repair of the Glenoid Labrum and Possibly Full Excision of Distal Clavicle & Mumford Procedure:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** According to the California MTUS/ACOEM Guidelines, surgical consideration may be indicated for those who have red flag conditions, activity limitation for more than 4 months, failure to increase function despite conservative therapy, and clear clinical and imaging evidence noting a lesion. The clinical documentation submitted for review indicated the injured worker had decreased function and clinical findings to warrant a surgical procedure; however, there was no documentation noting previous conservative therapy to include physical therapy. Additionally, an official imaging study was not provided to support the findings as indicated. Consequently, the request is not supported. As such, the request for right shoulder arthroscopy, subacromial decompression, SLAP tear repair of the glenoid labrum, and possibly full excision of distal clavicle and Mumford procedure is not medically necessary.

**Post-Operative Physiotherapy (3 time per week for 4 week for the right 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.

**Post-Operative Acupuncture (2 times weekly for 6 weeks for the right 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.

**Shoulder Abduction Pillow Brace, Micro Cool:** 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.

**IFC (interferential) Unit & Supplies:** 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.

**TENS (transcutaneous electrical nerve stimulation) Unit with Supplies:** 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.

**Exercise Kit:** 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.

**Motorized Compression 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.