

<b>Case Number:</b>	CM15-0061470		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	06/30/2011
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2015

### 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

### 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 67 year old male, who sustained an industrial injury on 6/30/2011. The mechanism of injury was not provided for review. The injured worker was diagnosed as having left rotator cuff tear, right hip sprain/strain, left shoulder internal derangement, neck sprain/strain, lumbar sprain/strain and right hip internal derangement. There were no recent diagnostic studies included for review. Treatment to date has included physical therapy and medication management. In progress notes dated 10/21/2014 and 3/6/2015, the injured worker complains of lumbar spine pain, cervical pain and left shoulder pain. The treating physician is requesting left shoulder arthroscopic surgery and 12 post-operative physical therapy visits for the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic Surgery, Left Shoulder QTY 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 210. Decision based on Non-MTUS Citation Official Disability Guidelines, Acromioplasty surgery.

**Decision rationale:** According to the 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. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 3/6/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 3/6/15 does not demonstrate evidence satisfying the above criteria. Therefore the determination is not medically necessary.

**Associated Surgical Service- Post-op Physical Therapy, 3 times weekly for left shoulder:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.