

<b>Case Number:</b>	CM15-0069950		
<b>Date Assigned:</b>	04/17/2015	<b>Date of Injury:</b>	09/18/2008
<b>Decision Date:</b>	05/20/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/13/2015

### 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 60-year-old female, who sustained an industrial injury on 09/18/2008. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having bilateral knee internal derangement, lumbar disc herniation at multiple levels, lumbosacral strain with radicular symptoms, and right shoulder tendinitis. Treatment to date has included acupuncture and medication regimen. In a progress note dated 02/26/2015 the treating physician reports complaints of bilateral shoulder pain and stiffness along with tenderness over the biceps tendon and over the right acromioclavicular joint and positive impingement signs to the bilateral shoulders. The treating physician requested right shoulder arthroscopy, but the documentation provided did not indicate the specific reason for the requested procedure. The documentation provided did not include the requested equipment of ThermaCare with a 30-day rental, purchase of a ThermaCare Pad, and purchase of a sling with an abduction pillow for the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ThermaCare (30-day rental): 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

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

**Sling with Abduction Pillow for the Right Shoulder (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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Right Shoulder Arthroscopy: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 2092-10. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, 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 2/26/15. 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 2/26/15 does not demonstrate evidence satisfying the above criteria. Therefore, the request is not medically necessary.

