

<b>Case Number:</b>	CM13-0001137		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	02/21/2013
<b>Decision Date:</b>	02/04/2014	<b>UR Denial Date:</b>	06/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 32-year-old male who reported an injury on 02/21/2013. The mechanism of injury was stated to be the patient was punched in the face and thrown against a door, and hit their left shoulder. A couple of days later the patient was noted to have wrestled another student to the floor. The patient was noted to have participated in 16 physical therapy sessions. The patient was noted to have an MRI on 03/06/2013 which revealed the patient had an obliquely oriented high grade partial thickness intrasubstance tear of the central and anterior fibers of the supraspinatus tendon with concomitant mild to moderate supraspinatus tendonitis and there was noted to be a suspected superior and labral tear from approximately the 9 o'clock to the 11 o'clock position as well as mild acromioclavicular joint osteoarthritis. The patient's physical examination revealed the patient had pain and had an inability to sleep. The patient's pain was noted to be constant at night. The diagnoses were noted to include left shoulder high grade partial thickness tear of the supraspinatus portion of the rotator cuff and left shoulder superior and posterior labral tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 left shoulder arthroscopy with rotator cuff repair, labral repair and Mumford procedure: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, Chronic Pain Treatment Guidelines Shoulder Surgery. Decision based

on Non-MTUS Citation Official Disability Guidelines, Shoulder Section, Indications for Surgery, Rotator Cuff repair.

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

**Decision rationale:** ACOEM guidelines indicate for rotator cuff tears, the patient must have conservative care for 3 months, and patients who have significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers and patient's must have findings of a rotator cuff tear on MRI. Surgery is not indicated for patients with mild symptoms or those whose activities are not limited. The clinical documentation submitted for review indicated the patient had 16 sessions of physical therapy that was not helpful. The patient was noted to have pain at night and have an inability to sleep. The objective examination revealed the patient had flexion of 90 degrees, abduction of 80 degrees, extension of 35 degrees, internal rotation of 70 degrees, and external rotation of 75 degrees. The patient was noted to have pain with range of motion. There were positive findings on the MRI. The request for the portion of the surgery, rotator cuff repair would be supported with clinical documentation. Official Disability Guidelines recommend repair for a type II and type IV lesion if more than 50% of the tendon is involved. However, the request for the labral repair would not be supported as there was a lack of documentation indicating the patient had a tear on MRI. As such, the request for the SLAP lesion portion, labral repair would not be supported. Official Disability Guidelines indicate the criteria for a Mumford procedure include the patient to have conservative care and aggravation or pain with shoulder motion or carrying weight as well as tenderness over the AC joint and/or pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial plus imaging findings of posttraumatic changes of the AC joint or severe DJD of the AC joint. The clinical documentation submitted for review failed to support the above criteria. Given the above, the request for 1 left shoulder arthroscopy with rotator cuff repair, labral repair, and Mumford procedure is not medically necessary.

**4 day rental of 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.

**14 day rental of 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.

**30 day rental of IF 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.

**30 day rental of continuous passive motion machine (CPM):** 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.

**1 prescription of Omeprazole 20mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, page 69. Page(s): 69.

**Decision rationale:** California MTUS recommends PPI's for patients who have dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide the efficacy of the requested medication and failed to provide the necessity for the medication as there as a lack of documentation of signs and symptoms of dyspepsia. Given the above, the request for 1 prescription of Omeprazole 20 mg #60 is not medically necessary