

<b>Case Number:</b>	CM13-0004799		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	04/05/2012
<b>Decision Date:</b>	01/31/2014	<b>UR Denial Date:</b>	07/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2013

### 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, has a subspecialty in Hand Surgery and is licensed to practice in Georgia and Texas. 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 54-year-old male who reported an injury on 04/05/2012. The patient is currently diagnosed with chronic probable interstitial tear at attachment of supraspinatus to superior end of facets of the greater tuberosity and supraspinatus tendinopathy. The patient was seen by [REDACTED] on 07/15/2013. The patient reported persistent bilateral shoulder pain. Physical examination revealed tenderness to palpation of the bilateral shoulders, full range of motion of the bilateral shoulders, pain at about 90 degrees of flexion and abduction and 2+ bilateral deep tendon reflexes. Treatment recommendations included a left shoulder surgery and continuation of current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **SHOULDER ARTHROSCOPY, ROTATOR CUFF REPAIR: 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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Surgery for rotator cuff repair.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state that a referral for a surgical consultation may be indicated for patients who have red flag conditions, activity limitations for more than 4 months, failure to increase range of motion and strength around the shoulder after exercise programs and clear clinical and imaging evidence of a lesion. As per the clinical notes submitted, the patient underwent an MR arthrogram of the left shoulder on 11/26/2012 which indicated normal findings. The patient's latest physical examination noted normal range of motion of the bilateral shoulders. According to the office visit dated 03/25/2013, a repeat MRI was noted to reveal a partial tear of the rotator cuff. However, the official imaging study was not provided for review. Based on the clinical information received, the patient does not currently meet the criteria for the requested surgical procedure. As such, the request is non-certified.

**PRE OP MEDICAL CLEARANCE:** 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) Low Back Chapter, Preoperative Testing, General

**Decision rationale:** The Official Disability Guidelines state that pre-operative testing is often performed before surgical procedures. The decision to order pre-operative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. As the patient's surgical procedure has not been authorized, the current request for pre-operative medical clearance is not medically necessary. As such, the request is non-certified.

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous-flow cryotherapy.

**Decision rationale:** The Official Disability Guidelines state that continuous flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use. As the patient's surgical procedure has not been authorized, the current request for postoperative DME is also not medically necessary. Therefore, the request is non-certified.

**POST OP PHYSICAL THERAPY X 16-24:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state that the initial course of therapy means 1/2 of the number of visits specified in a general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. Postsurgical treatment following an arthroscopic rotator cuff repair includes 24 visits over 14 weeks. While the patient may meet the criteria for postoperative physical therapy following a rotator cuff repair, the patient's surgical procedure has not been authorized, and the current request exceeds guideline recommendations. Therefore, the request is non-certified.