

<b>Case Number:</b>	CM13-0068438		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	07/27/1995
<b>Decision Date:</b>	04/17/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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 50-year-old male with an industrial injury on 7/27/95. The patient suffers from chronic left shoulder pain. An MRI (magnetic resonance imaging) from 11/13/13 demonstrated evidence of a prior rotator cuff repair and mild recurrent partial tearing, chondromalacia of the glenohumeral joint, and significant to severe degenerative changes of the acromioclavicular (AC) joint. Corticosteroid injection on 10/7/13 made a slight improvement to pain. The exam notes from 11/18/13 demonstrate positive arc of pain, negative drop arm test, positive impingement sign, positive pain and 30% weakness on manual resistive muscle strength testing. The exam also revealed positive AC joint tenderness, positive biceps tenderness and positive O'Brien's test. Request for left shoulder evaluation manipulation, Superior Labrum Anterior and Posterior (SLAP) repair, scope debridement, Mumford procedure, and subacromial decompression.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) left shoulder evaluation manipulation, SLAP repair, scope with debridement, Mumford procedure, subacromial: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** There is no evidence in the records of recent failure of conservative care for at least 6 weeks per the Official Disability Guidelines (ODG). In addition the MRI (magnetic resonance imaging) report from 11/13/13 does not demonstrate a labral tear. Therefore the determination is for non-certification.

**One (1) cold therapy unit ( [REDACTED] ): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. Thus, as the surgical procedure is non-certified, the decision for one cold therapy unit is non certified.

**One (1) TENS unit ( [REDACTED] ): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. Thus, as the surgical procedure is non-certified, the decision for one transcutaneous electrical nerve stimulation (TENS) unit is non certified.

**One (1) shoulder sling with abductor pillow ( [REDACTED] ): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. Thus, as the surgical procedure is non-certified, the decision for one shoulder sling is non-certified.

**24 post- op physical therapy visits: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. Thus, as the surgical procedure is non-certified, the decision for 24 post op physical therapy visits is non-certified

**12 Keflez 500 mg, post-op medication: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. Thus, as the surgical procedure is non-certified, the decision for 12 Keflex 500 mg postop medication is non-certified.

**20 Zofran 8 mg, post op medication: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. Thus, as the surgical procedure is non-certified, the decision for 20 Zofran 8 mg postop medication is non-certified.

**10 Lunesta 3 mg, post op medication: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. Thus, as the surgical procedure is non-certified, the decision for 10 Lunesta 3 mg, post op medication is non-certified.

**60 Mobib 7.5 mg, post op medication:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. Thus, as the surgical procedure is non-certified, the decision for 60 Mobib 7.5 mg, post op medication is non-certified.

**30 Norco 7.5/325 mg, post op medication:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Labral tear, Partial Claviclectomy, rotator cuff repair

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary. Thus, as the surgical procedure is non-certified, the decision for 30 Norco 7.5/325 mg, post op medication is non-certified.