

<b>Case Number:</b>	CM13-0069548		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	05/11/2010
<b>Decision Date:</b>	06/04/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2013

### 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. The expert 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 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/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 injured worker is a 44-year-old male who reported an injury on 05/11/2010 after an electrocution. The injured worker reportedly sustained an injury to the right shoulder as well as multiple burns and a traumatic brain injury. The injured worker's treatment history included skin grafts, walking cane, a continuous positive airway pressure (CPAP) machine, psychotherapy, and multiple medications, chiropractic care, and physical therapy for the shoulder and lumbar spine. The most recent clinical evaluation from the requesting provider was dated 07/18/2013. It was documented that the injured worker continued to complain of shortness of breath and low back pain radiating into the right lower extremity. It was also documented that the injured worker had increased right shoulder pain. Objective findings included decreased range of motion and there is 100 degrees in flexion of the right shoulder. The injured worker's diagnoses included status post severe electrocution with extensive body burns, severe obstructive sleep apnea (OSA), erectile dysfunction, middle ear trauma, traumatic brain injury, right shoulder tear, depression, and low back pain. The injured worker's treatment plan included referral to an orthopedic surgeon for the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ARTHROSCOPY ACROMIOPLASTY ROTATOR CUFF REPAIR OF THE RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter (acute and chronic), and Low Back-Lumbar & Thoracic (acute and chronic), and Gladstone, J. N., Bishop, J. Y., Lo, I, K. and Flalow, E. L. (2007). Fatty infiltration and atrophy of the rotator cuff do not improve after rotator cuff repair and correlate with poor functional outcome. American Journal of Sports Medicine, 35(5), 719-28. <http://www.ncbi.nlm.nih.gov/pubmed/17337727>.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**Decision rationale:** The American College of Occupational and Environmental Medicine recommends surgical intervention for impingement syndrome be supported by documentation of significantly restricted functional capabilities, positive clinical exam findings, and an imaging study. The clinical documentation submitted for review did not include a recent physical assessment of the injured worker's right shoulder to support the need for surgical intervention. Additionally, an imaging study was not provided for review to support the appropriateness of surgical intervention at this time. Moreover, the clinical documentation submitted for review did not clearly identify all conservative treatments directed towards the right shoulder to support the need for surgical intervention. As such, the requested arthroscopy acromioplasty rotator cuff repair of the right shoulder is not medically necessary or appropriate.

**SURGICAL CLEARANCE WITH INTERNIST:** 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), Shoulder chapter (acute and chronic), and Low Back-Lumbar & Thoracic (acute and chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.