MAXIMUS Federal Services

| Case Number: | CM13-0070582 | | |
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| Date Assigned: | 01/17/2014 | Date of Injury: | 04/14/1986 |
| Decision Date: | 05/29/2014 | UR Denial Date: | 11/26/2013 |
| Priority: | Standard | Application Received: | 12/24/2013 |

## 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 Orthopaedic 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:

This 62-year-old female sustained an industrial injury on 4/14/86. She underwent right shoulder arthroscopy with subacromial decompression in 2002. Past medical history is positive for cervical disc herniation with radiculitis/radiculopathy. She is also status post right elbow ulnar nerve transposition and right carpal tunnel release. The 2/12/12 right shoulder MRI (magnetic resonance imaging) revealed a rotator cuff tear. The 5/30/13 treating physician letter stated the patient had restricted right shoulder range of motion causing difficulty with activities of daily living, including inability to lift over 10 pounds. Pain woke her at night. The patient had failed medications and activity restrictions. She had failed physical therapy for flare-ups. The 9/5/13 report cited right shoulder pain and quality of life impaired. Objective findings noted restricted shoulder flexion, extension, abduction, and adduction with a positive impingement test. The diagnosis was adhesive capsulitis and recurrent cuff tear. The treatment plan recommended right shoulder arthroscopic surgery, subacromial decompression and rotator cuff repair. The 10/28/13 right shoulder MRI revealed a partial rotator cuff tear and glenohumeral joint osteoarthritis.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT SHOULDER ARTHROSCOPY SUBACROMIAL DECOMPRESSION ROTATOR CUFF REPAIR (CRC):** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff repair

**Decision rationale:** The Official Disability Guidelines (ODG) for rotator cuff repair of partial thickness tears generally require: 3 months of continuous to 6 months of intermittent conservative treatment; plus painful arc of motion 90-130 degrees and nighttime pain; plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test; plus imaging evidence plantar flexion deficit in the rotator cuff. The guideline criteria have been met. There is documentation that reasonable comprehensive conservative treatment had been tried and failed. The clinical findings are corroborated by imaging findings. Therefore; the request for right shoulder arthroscopy subacromial decompression and rotator cuff repair is medically necessary.

**INTERNAL MEDICINE CLEARANCE:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Specialist clearance is appropriate for select patients. The guidelines criteria have been met. The patient is over 62 with a history of gastritis. Middle-aged females have known occult increased medical/cardiac risk factors. Therefore, this request for internal medicine clearance is medically necessary.