

<b>Case Number:</b>	CM14-0005815		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	12/15/2006
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	12/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2014

### 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:

This is a 63-year-old male with a 12/15/06 date of injury. The patient injured both of his shoulders, due to repetitive work. On 12/6/13, the patient had low back pain, which he rates as a 5-7/10. He had bilateral shoulder pain, left greater than right, which he rates from a 5-9/10. The pain is associated with weakness, numbness, and swelling. The pain radiates to the head, neck, arms, and hands. He is unable to perform his activities of daily living secondary to the pain. Objective exam of the left shoulder: 140 degrees of flexion and abduction, 40 of extension, and 70 of internal/external rotation. His ROM was restricted by pain. Muscle strength testing was 4/5. A MRI of the left shoulder on 10/10/12 shows fluid surrounding the biceps tendon in the bicipital groove likely representative of tenosynovitis. There is AC joint impingement, tear of supraspinatus tendon at the insertion site, and a subchondral cyst of the posterior aspect of the humeral head. Diagnostic Impression: left shoulder bursitis, Complete rupture of left rotator cuff, left shoulder derangement, left shoulder impingement syndrome. Treatment to date: physical therapy, acupuncture, lumbar ESI, s/p right shoulder surgery, chiropractic care, and medication management. A UR decision dated 12/26/13 denied the request based on the fact that there was no evidence that the patient had a full-thickness lesion. There was no documentation of conservative care including cortisone injections that should be carried out for at least 3 to 6 months before considering surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LEFT SHOULDER ARTHROSCOPY WITH POSSIBLE ACROMIOPLASTY, ROTATOR CUFF REPAIR AND SUBACROMIAL DECOMPRESSION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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.

**Decision rationale:** MTUS states that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation; conservative treatment of full thickness rotator cuff tears has results similar to surgical treatment, but without the surgical risks, and further indicate that surgical outcomes are not as favorable in older patients with degenerative changes about the rotator cuff. In addition, ODG criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. However, although the physician documents the patient has a full-thickness rotator cuff tear, there is no MRI report to document this. It was documented that there was a MRI of the left shoulder done in 2012, however, the official report was not provided for review. The MRI from 2012 showed tenosynovitis and AC joint arthrosis, but showed no evidence of a full-thickness rotator cuff tear. In addition, conservative management aimed toward the left shoulder was not clearly documented. On the most recent progress note, it was noted that the patient had decreased range-of-motion, but it was unclear if it was active or passive range-of-motion. Therefore, the request, as submitted, for Left Shoulder Arthroscopy with Possible Acromioplasty, Rotator Cuff Repair, and Subacromial Decompression was not medically necessary.

**Pre-Op Medical Clearance with Labs: 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.

**Post-Op PT 3 X 4: 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.

**Left Post-Op Shoulder Brace:** 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.

**Abduction Pillow Sling:** 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.

**Cold Therapy Unit Rental X 14 days:** 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.