

<b>Case Number:</b>	CM14-0006003		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	03/05/2005
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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:

The patient is a 47-year-old female who has submitted a claim for Right Shoulder Rotator Cuff Tear associated with an industrial injury date of March 5, 2005. Medical records from 2013 were reviewed, which showed that the patient complained of right shoulder pain, increased by reaching, pushing, and pulling. On physical examination, there was tenderness of the right shoulder along the acromion. Impingement sign was positive. There was noted right shoulder weakness in abduction and external rotation. Drop arm test was negative. MR Arthrogram of the right shoulder, dated November 1, 2013, revealed minor extra-articular gadolinium likely postsurgical in etiology, no retracted rotator cuff tear or re-tear, and prominent subdeltoid bursitis with degenerative marrow edema and synovitis prominent to the acromioclavicular joint. Treatment to date has included medications, activity modification, subacromial steroid injection, and right shoulder arthroscopy. utilization review from December 10, 2013 denied the request for right shoulder arthroscopy w/ arthroscopic rotator cuff repair because there was no documentation of recent therapy; and registered nurse evaluation for home health care for the purpose of wound cleaning, assistance w/ daily living activities four hours daily per two weeks post operation, pain pump, deep vein thrombosis prophylaxis, combo care 4 electrotherapy for 30 days of therapy, ultra sling w/ pillow, and 12 post operation physical therapy because the surgery was not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT SHOULDER ARTHOSCOPY W/ARTHROSCOPIC ROTATOR CUFF REPAIR:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9, 209,211

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**Decision rationale:** According to pages 209-211 of the ACOEM Practice Guidelines referenced by CA MTUS, rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation. For partial full-thickness and small tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy. In addition, conservative care including cortisone injections can be carried out for at least three to six months before considering surgery. In this case, MR Arthrogram findings revealed minor extra-articular gadolinium likely postsurgical in etiology and no retracted rotator cuff tear or re-tear. Evidence of impingement was found on physical examination; however, imaging findings did not support the diagnosis of a rotator cuff tear. Therefore, the request for Right Shoulder Arthroscopy W/ Arthroscopic Rotator Cuff Repair is not medically necessary.

**REGISTERED NURSE EVALUATION FOR HOME HEALTH CARE FOR THE PURPOSE OF WOUND CLEANING:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9, 209,211

**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.

**ASSISTANCE W DAILY LIVING ACTIVITIES FOUR HOURS DAILY PER TWO WEEKS POST OPERATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9, 209,211

**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.

**PAIN PUMP:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9, 209,211

**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.

**DEEP VEIN THROMBOSIS PROPHYLAXIS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9, 209,211

**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.

**COMBO CARE 4 ELECTROTHERAPY FOR 30 DAYS OF THERAPY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9, 209,211

**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.

**ULTRA SLING W PILLOW:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9, 209,211

**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.

**12 POST OPERATION PHYSICAL THERAPY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 9, 209,211

**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.