

<b>Case Number:</b>	CM14-0127846		
<b>Date Assigned:</b>	08/15/2014	<b>Date of Injury:</b>	04/05/2011
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	07/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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 76-year-old male sustained an industrial injury on 4/5/11. The injury occurred when he was struck from behind by a bicyclist. Past medical history was positive for type 2 diabetes. The patient was status post C5/6 anterior cervical discectomy and fusion on 3/22/12 and right rotator cuff repair on 9/14/12. He underwent right shoulder manipulation under anesthesia, revision acromioplasty, and extensive debridement with capsular release on 12/17/13. Records indicated post-op physical therapy was initiated on 1/2/14; no subsequent physical therapy records or progress reports were available. The 6/5/14 right shoulder MRI impression documented high grade partial tearing and atrophy of the subscapularis and fraying of the infraspinatus. The humeral head had begun to migrate superiorly. The 7/7/14 treating physician clinical note cited right shoulder pain, weakness and loss of motion. Physical exam documented active right shoulder flexion 120 degrees and passive flexion 150 degrees. External rotation was 30 degrees and internal rotation was to L3. External rotation and abduction strength was 5/5. Palm up supraspinatus testing was 4/5. Lift-off, belly, and bear-hug tests were positive. Speed and Yergason's tests were negative. The diagnosis was right shoulder partial thickness tearing of the subscapularis and supraspinatus tendon. The patient had been extremely compliant with post-operative care but remained disabled by pain and loss of function in the right upper extremity. The treatment plan recommended arthroscopy with possible revision arthroscopic versus open rotator cuff repair and extensive arthroscopic debridement. The 7/18/14 utilization review denied the right shoulder surgery and associated requests based on no documentation of interval failure of conservative treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopic versus open rotator cuff repair and debridement: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 2013 Official Disability Guidelines, 18th edition, Surgery for rotator cuff repair, ODG Indications for Surgery - Rotator cuff repair.

**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 California MTUS does not provide specific recommendations for revision rotator cuff repairs. The Official Disability Guidelines for rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment. Subjective criteria include pain with active arc of motion 90 to 130 degrees and pain at night. Objective criteria include weak or absent abduction and tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of rotator cuff deficit are required. Guidelines state that the results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. There is no documentation of positive impingement or diagnostic injection testing. This patient has undergone two prior rotator cuff procedures. Therefore, this request is not medically necessary.

**Pre-operative labs: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Pre-operative EKG: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Pre-operative medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.