

<b>Case Number:</b>	CM14-0156396		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	06/02/2008
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	09/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2014

### 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 Texas. 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 68-year-old female who reported an injury on 06/02/2008. The mechanism of injury was not submitted for clinical review. The diagnoses included status post right shoulder arthroscopy with subacromial decompression and rotator cuff repair, left shoulder impingement syndrome with rotator cuff tear, cervical disc disease, lumbar strain disc disease. The previous treatments included physical therapy, surgery, and medications. Within the clinical note dated 07/25/2014, it was reported the patient was status post a right shoulder arthroscopy with subacromial decompression. She complained of neck pain and low back pain, as well as pain to the left shoulder. The patient reported having no improvement with physical therapy. Upon physical examination, the provider noted the right shoulder range of motion was forward flexion from 0 to 175 degrees. There was weakness with abduction testing. The left shoulder range of motion was forward flexion from 0 to 170 degrees. External rotation was from 0 to 40 degrees. The patient had a positive Hawkins sign for impingement syndrome with weakness in abduction testing. The provider recommended the injured worker to undergo a left shoulder arthroscopy with subacromial decompression for rotator cuff repair, due to no improvement with conservative treatment. However, the request submitted was for a right shoulder arthroscopic subacromial decompression and cuff synovectomy. The request for authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Surgery right shoulder arthroscopy, subacromial decompression and cuff synovectomy; for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**Decision rationale:** The request for surgery of the right shoulder arthroscopy, subacromial decompression, and cuff synovectomy for right shoulder is not medically necessary. The California MTUS/ACOEM Guidelines state rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. Rotator cuff tears are frequently partial thickness or smaller full thickness tears. For partial thickness tears, rotator cuff tears, and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The preferred procedure is usually arthroscopic decompression, which involves debridement of inflamed tissues, burning of the anterior acromion, lysis, and sometimes removal of the coracoacromial ligament, and possibly removal of the outer clavicle. Surgery is not indicated for patients with mild symptoms or those whose activities are not limited. The injured worker has undergone physical therapy with no improvement. However, the clinical documentation submitted failed to indicate the injured worker had activity limitations. An Official MRI was not submitted for clinical review warranting the medical necessity for the request. Additionally, the injured worker has previously undergone a right shoulder arthroscopy, subacromial decompression, and cuff synovectomy for the right shoulder. An additional surgery on the same shoulder would not be warranted. Therefore, the request is not medically necessary.

**Pre-op medical clearance:** 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) Guidelines

**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 operation physical therapy two times a week for 8 weeks for the right shoulder Qty: 16:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Guidelines shoulder chapter

**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.

**DME: DVT prophylaxis compression cuffs:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The article : "Deep Venous Thrombosis Prophylaxis in Orthopedic Surgery"

**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.

**DME: Q-Tech Cold therapy:** 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.