

<b>Case Number:</b>	CM14-0178815		
<b>Date Assigned:</b>	11/03/2014	<b>Date of Injury:</b>	08/13/2012
<b>Decision Date:</b>	12/08/2014	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/28/2014

### 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 Minnesota. 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 44 year old male with a history of right shoulder pain related to a lifting injury of 8/13/2012. He has had 24 physical therapy sessions and 3 cortisone injections. He underwent an MRI scan of the shoulder on 11/1/2012, but the report is not included. The initial notes indicate that the MRI revealed degeneration of the superior labrum and partial detachment. There was no mention of a cuff tear. A subsequent note of 2/10/2014 indicates the diagnosis of mild to moderate rotator cuff tendinosis and subacromial bursitis with at least a partial thickness rotator cuff tear. A more recent note of 9/15/2014 indicates a complete rotator cuff tear, fluid in the subacromial bursa, type II acromion, and degenerative spurring at the acromioclavicular joint. Examination findings indicate shoulder pain of moderate intensity exacerbated by reaching and pushing activities, positive Neer, Hawkin's and Jobe's tests and tenderness over the acromioclavicular joint. The disputed issues pertain to the request for right shoulder arthroscopic rotator cuff repair, acromioplasty, and distal clavicle resection, post-operative ultrasling, and 12 post-operative physical therapy sessions. The requested surgery was non-certified by UR because of the absence of a radiology report indicating the presence of a rotator cuff tear, its size, and location. Also there is no documentation indicating the presence of severe acromioclavicular arthritis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopic rotator cuff repair acromioplasty, and distal clavicle resection:**  
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) Indications for Surgery - Rotator Cuff; Diagnostic Arthroscopy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**Decision rationale:** The California MTUS guidelines require clear clinical and imaging evidence of a lesion that has been shown to benefit in both short and long term from surgical repair. Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation. The documentation provided does not include a radiology report pertaining to the MRI scan of the right shoulder. Therefore, the size and type of tear and the location is not known. The available notes provide conflicting information about the MRI findings as noted above in the summary. Also, presence of severe acromioclavicular arthritis is not documented. Therefore, the medical necessity of a rotator cuff repair and distal clavicle resection is not established per guidelines.

**One urinalysis:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**12 postoperative physical therapy sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.