

<b>Case Number:</b>	CM14-0027227		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	02/01/2012
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 Orthopaedic 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 60-year-old male sustained an industrial injury on 2/1/12, relative to a trip and fall onto his left side. The patient underwent left shoulder arthroscopy with extensive labral debridement, long head biceps tenotomy, subacromial decompression, and rotator cuff repair on 8/12/12. The patient changed treating physicians on 11/15/13. The new treating physician documented significant persistent pain and opined a possible recurrent rotator cuff tear. There were positive impingement tests. A left shoulder diagnostic injection was positive. An MR arthrogram of the left shoulder was recommended. The 12/4/13 left shoulder MR arthrogram impression documented evidence of previous rotator cuff repair with high-grade partial thickness supraspinatus tearing involving 75% of the tendon fibers. There was subscapularis tendinosis with partial thickness tearing. There was tearing and separation of the superior labrum from the underlying chondral surface with degenerative changes of the remaining labrum. There was moderate acromioclavicular (AC) joint arthrosis with mass effect on the underlying supraspinatus myotendinous junction. The 1/10/14 treating physician report cited grade 8-9/10 left shoulder pain with activity, 5-6/10 at rest. The patient was not working. The left shoulder exam documented abduction 160 degrees, flexion 145 degrees, extension/adduction 10 degrees, external rotation 70 degrees, and internal rotation 35 degrees. Strength was 4/5 in internal/external rotation. The treating physician stated patient underwent surgery in 2012 with persistent high-level shoulder pain. Surgery made him worse, not better. MRI documented persistent AC arthropathy with impingement. The repair appeared grossly intact with residual high-grade partial thickness tear. The patient had failed conservative treatment, including physical therapy. The treatment plan recommended revision left shoulder arthroscopy with decompression, Mumford, and possible rotator cuff repair. The 1/30/14 utilization review denied the request for right shoulder arthroscopy based on the 11/5/13 Agreed Medical Evaluation

opinion that the patient was not considered in current need of additional surgical intervention to the shoulder.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **RIGHT SHOULDER ARTHROSCOPY: 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 Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff repair, Surgery for impingement syndrome, Partial claviclectomy.

**Decision rationale:** The California MTUS guidelines do not address shoulder surgeries for chronic injuries. The Official Disability Guidelines for rotator cuff repair and acromioplasty generally require 3 to 6 months of conservative treatment, and subjective, objective, and imaging clinical findings consistent with impingement. Guideline criteria for partial claviclectomy generally require directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have not been met for right shoulder surgery. This patient presents status post left shoulder surgery with significant persistent left shoulder pain and clinical findings of impingement consistent with imaging. The patient has failed guideline-recommended conservative treatment, including physical therapy, home exercise, activity modification, and medications relative to the left shoulder. The treating physician recommended left shoulder arthroscopy with revision decompression, Mumford, and possible rotator cuff repair. While surgery would be supported for the left shoulder, the current request under consideration is for the right shoulder. There is no clinical exam or imaging evidence to support surgery for the right shoulder. Therefore, this request for right shoulder arthroscopy is not medically necessary.

#### **COLD THERAPY UNIT: 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 Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy.

**Decision rationale:** As the right shoulder arthroscopy is not medically necessary, the request for one cold therapy unit is also not medically necessary.

#### **ULTRASLING: 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 Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

**Decision rationale:** As the request for right shoulder arthroscopy is not medically necessary, the request for an UltraSling is also not medically necessary.

**PHYSICAL THERAPY X 12:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** As the request for right shoulder arthroscopy is not medically necessary, the request for physical therapy x 12 is also not medically necessary.