

<b>Case Number:</b>	CM14-0032493		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	04/27/2013
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	01/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 claimant is a 80 year old female with complaint of neck pain and numbness and tingling in bilateral fingers. Exam note 1/6/14 demonstrates complaint of pain and discomfort in the right shoulder. Examination demonstrates severely limited motion of the right shoulder. Report of severe tenderness over the coracoacromial ligaments and subacromial space. Positive drop arm and impingement test. MRI right shoulder 8/4/13 demonstrates full thickness complete tear of the supraspinatus tendon with 3 cm retraction.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ASSISTANT SURGEON:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation: American Association Of Orthopaedics Surgeons.

**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.

**INTERNAL MEDICINE CLEARANCE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
[HTTP://WWW.GUIDELINE.GOV/CONTENT.ASPX?ID=38289](http://www.guideline.gov/content.aspx?id=38289) PREOPERATIVE EVALUATION.

**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.

**RIGHT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561.

**Decision rationale:** According to the MTUS/ACOEM guidelines, regarding rotator cuff tear, "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 partialthickness or smaller full thickness tears. For partial-thickness rotator cuff tears and small fullthickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, which involves debridement of inflamed tissue, burring 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." In this case, the claimant has a large retracted rotator cuff repair consistent with rotator cuff arthropathy. There is insufficient evidence of conservative care being performed or temporary relief with anesthetic injections. Therefore the requested right shoulder arthroscopic subacromial decompression is not medically necessary and appropriate.