

<b>Case Number:</b>	CM14-0045732		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	02/14/1998
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/15/2014

### 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 is a 52 year old male with a 2/14/98 injury date. In 2007, the injured worker had a right shoulder magnetic resonance imaging (MRI) which apparently revealed a full-thickness transverse tear of the anterolateral corner of the supraspinatus tendon. Surgery was recommended but the injured worker declined, preferring conservative treatment. In a 2/4/14 note, the injured worker complained of worsening right shoulder pain with some loss of movement and difficulty with many activities. Objective findings included 140 degrees of forward flexion and abduction, moderately diminished rotation, positive impingement signs, and weakness of the supraspinatus and infraspinatus. The provider noted that the injured worker did reasonably well with physical therapy and cortisone injections several years ago but there has not been any treatment since. A more recent right shoulder MRI on 3/10/14 showed a partial thickness tear of the anterolateral supraspinatus tendon on the bursal side. Diagnostic impression: right shoulder rotator cuff tear. Treatment to date: physical therapy, medications, injections. A UR decision on 4/4/14 denied the request for right shoulder arthroscopy, debridement, decompression, Mumford, and rotator cuff repair because there was no evidence of a full-thickness cuff tear on MRI and there was no documentation of any conservative treatment in the last several years. The requests for pre-op labs, EKG, chest x-ray, post-op physical therapy, ultra-sling, and cold therapy unit were denied because the associated procedures were not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy, Debridement, Decompression, Mumford, Rotator Cuff Repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter--Rotator Cuff Repair, Mumford, Surgery for Impingement Syndrome

**Decision rationale:** CA MTUS states that rotator cuff repair is indicated for "significant tears that impair activities by causing weakness of arm elevation or rotation; conservative treatment of full thickness rotator cuff tears has results similar to surgical treatment, but without the surgical risks, and further indicate that surgical outcomes are not as favorable in older patients with degenerative changes about the rotator cuff." In addition, ODG criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. CA MTUS states that surgery for impingement syndrome is usually "arthroscopic decompression (acromioplasty)." However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should "include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair." Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. ODG supports partial claviclectomy (including Mumford procedure) with imaging evidence of significant AC joint degeneration along with physical findings (including focal tenderness at the AC joint, cross body adduction test, active compression test, and pain reproduced at the AC joint with the arm in maximal internal rotation may be the most sensitive tests), and pain relief obtained with an injection of anesthetic for diagnostic purposes. Non-surgical modalities includes at least 6 weeks of care directed towards symptom relief prior to surgery including anti-inflammatories and analgesics, local modalities such as moist heat, ice, or ultrasound. However, there was no documentation of any conservative treatment over the last several years that were directed toward the right shoulder condition. In addition, the most recent MRI did not demonstrate a full-thickness rotator cuff tear. There was no documentation of tenderness over the acromioclavicular joint or positive cross-body adduction test to warrant a Mumford procedure. Therefore, the request for Right Shoulder Arthroscopy, Debridement, Decompression, Mumford, Rotator Cuff Repair is not medically necessary.

**Associated Surgical Service: Pre-Op Clearance to include Complete Blood Count (CBC), Basic Metabolic Panel (BMP), Electrocardiography (EKG) and Chest X-Ray: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 211.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter--Preoperative EKG and Lab testing. ACC/AHA 2007 Guidelines, Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery.

**Decision rationale:** CA MTUS does not address this issue. ODG states that pre-op testing can be helpful to "stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity." The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgeries who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. However, the associated surgical procedure was not certified. Therefore, the request for Pre-Op Clearance to include Complete Blood Count (CBC), Basic Metabolic Panel (BMP), Electrocardiography (EKG) and Chest X-Ray is not medically necessary.

**Associated Surgical Service: Post-Op Physical Therapy, 2-3 Times a Week for 4 Weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 211.

**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.

**Associated Surgical Service: Ultra-Sling:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 211.

**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

**Cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 211.

**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.