

<b>Case Number:</b>	CM14-0077188		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	03/16/2001
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	05/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 55 year old male who fell off of scaffolding and sustained a vocational injury on 03/16/01 while working as a steel operator. The medical records provided for review include an office note dated 07/31/14 documenting that the claimant had a massive rotator cuff tear of the right shoulder. Examination revealed a positive Hawkin's and Neer test. Diagnosis was massive rotator cuff tear for years, following an industrial injury. The report of an MRI of the left shoulder dated 03/29/14 identified a post-operative shoulder from a previous tendon repair, full thickness tear of the supraspinatus and infraspinatus tendon, tendinosis of the subscapularis tendon, partial thickness tear on the articulating side bordering the medial margin of the bicipital groove, muscle atrophy of the supraspinatus and portions of the infraspinatus muscle, cephalad migration of the humerus. Labral tear could not be excluded. It was noted that the claimant had two previous left shoulder procedures, one of which was an open rotator cuff repair, the second of which was done a few years later, but unfortunately, no specifics regarding the surgery were made available. Recent conservative treatment to date is not clearly delineated in the documentation presented for review. The current request is for left shoulder diagnostic arthroscopy, subacromial decompression and tissue repair of the labrum and rotator cuff.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder diagnostic arthroscopy and surgery, subacromial decompression (SAD) and tissue repair labrum or rotator cuff: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for surgery; Official Disability Guidelines, Shoulder (Acute and Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder chapter: Labrum tear surgery.

**Decision rationale:** Based on the California ACOEM Guidelines and the Official Disability Guidelines, the request for left shoulder diagnostic arthroscopy and surgery, subacromial decompression (SAD) and tissue repair labrum or rotator cuff is not recommended as medically necessary. The most recent office note available for review from 07/31/14 suggests that the claimant had right shoulder subjective complaints and abnormal physical exam objective findings; however, the MRI available for review from March of 2014 and the recent request suggests that the concerns are for the left shoulder. Currently, there is ambiguity with regards to the laterality of the shoulder that has been evaluated and for which surgical intervention is being requested. In addition, it is noted that the claimant has had two previous surgical interventions on the left shoulder and there is no documentation to support how the claimant would benefit from a functional standpoint, from a third surgery to the same extremity. Currently there is no documentation of the quality of the tissue which should have been noted from the two previous surgical interventions. Revision rotator cuff repairs are recommended only via second procedure and additional procedures are not considered medically necessary, based on Official Disability Guidelines. In addition, there is a lack of documented conservative treatment which should be undertaken and failed prior to considering a third surgery on the same extremity according to ACOEM Guidelines. Conservative treatment could include anti-inflammatories, activity modification, home exercise program, formal physical therapy, injection therapy, prior to considering surgical intervention. Therefore, based on the conflicting medical documentation provided for review and the California ACOEM and Official Disability Guidelines, the request for the left shoulder diagnostic arthroscopy and surgery, subacromial decompression and tissue repair labrum or rotator cuff cannot be considered medically necessary.

**Preoperative medical clearance:** 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.

**Preoperative chest and left shoulder Xray:** 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.

**Preoperative labs (unspecified):** 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.

**Preoperative EKG:** 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.

**Pain Pump:** 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.

**Shoulder sling with abduction pillow:** 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.

**Cold therapy unit rental for 30 days: 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.

**Eight (8) post-operative Physical Therapy sessions: 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.

**Six (6) post-operative office visits: 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.