

<b>Case Number:</b>	CM14-0187089		
<b>Date Assigned:</b>	11/17/2014	<b>Date of Injury:</b>	12/05/2013
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	10/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2014

### 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:

According to the records made available for review, this is a 51-year-old male with a 12/5/13 date of injury. At the time (10/31/14) of request for authorization for associated surgical service: (L) shoulder arthroscopy, associated surgical service: rotator cuff debridement versus repair, and associated surgical service: post-op PT (X12), there is documentation of subjective (left shoulder pain with forward flexion, external rotation, and internal rotation) and objective (external rotation 65 degrees with anterior pain, tender anteriorly over the bicipital groove/anterior cuff, pain with internal rotation from full external rotation, 165 degrees of forward flexion with only minimal discomfort) findings, imaging findings (left shoulder MRI (12/27/13) report revealed moderate subscapularis and supraspinatus tendinopathy, a cluster of cysts present along the posterior mid labrum with adjacent elevated labral signal intensity, the appearance suggests an underlying labral tear, mild biceps tendinopathy, and small subacromial spur), current diagnoses (left shoulder pain; continued shoulder pain with supraspinatus and subscapularis tendinosis, possible partial thickness subscapularis tear), and treatment to date (left shoulder steroid injection, medications, exercises, and physical therapy). 9/11/14 medical letter identifies that the patient has signs and symptoms consistent with a partial versus complete rotator cuff tear specifically involving the subscapularis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: (L) Shoulder Arthroscopy:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Indications for Surgery

**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, Subacromial Decompression

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of left shoulder pain. In addition, there is documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, subjective clinical findings: pain with active arc motion 90 to 130 degrees, objective clinical findings: tenderness over rotator cuff, and imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service: (L) shoulder arthroscopy is medically necessary.

**Associated surgical service: Rotator Cuff Debridement Versus Repair:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Indications for Surgery

**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, Subacromial Decompression

**Decision rationale:** MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy

and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of left shoulder pain. In addition, there is documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, subjective clinical findings: pain with active arc motion 90 to 130 degrees, objective clinical findings: tenderness over rotator cuff, and imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service: rotator cuff debridement versus repair is medically necessary.

**Associated surgical service: Post-Op PT (X12):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Â§ 9792.24. 3. Postsurgical Treatment Guidelines; and Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of left shoulder pain. In addition, there is documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service: post-op PT (X12) is medically necessary.