

<b>Case Number:</b>	CM14-0198770		
<b>Date Assigned:</b>	12/09/2014	<b>Date of Injury:</b>	06/06/2014
<b>Decision Date:</b>	02/04/2015	<b>UR Denial Date:</b>	11/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2014

### 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:

55-year-old female claimant with an industrial injury dated 06/06/14. MRI of the left shoulder reveals a supraspinatus tendinosis with mild irregularity along the articular surface, which may represent partial tear. It is also noted that there is a minute cystic structure at the musculotendinous junction measuring 4 x 1 mm, a partial subscapularis tear, degenerative change of the AC joint hyperemia which indents the supraspinatus, and trace joint effusion with subacromial and subdeltoid components. Exam note 10/31/14 states the patient returns with left shoulder pain. The patient rates the pain a 7-8/10 and pain is increased with repetitive movement. Upon physical exam there was evidence of tenderness surrounding the cervical back along with pain. The left shoulder range of motion was noted as 130' forward flexion and 110' abduction. There was bony tenderness and pain revealed with the range of motion test. Diagnosis is noted as left rotator cuff tear, left shoulder joint pain, and left shoulder contusion. Treatment includes a left shoulder arthroscopy rotator cuff debridement vs. repair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy rotator cuff debridement vs repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Surgery for rotator cuff repair.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 10/31/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 10/31/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the Left shoulder arthroscopy rotator cuff debridement vs repair is not medically necessary.

**Left shoulder acromioplasty:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, acromioplasty surgery.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 10/31/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 10/31/14 does not demonstrate evidence satisfying the above criteria. Therefore, the Left shoulder acromioplasty is not medically necessary.

**Left shoulder bursectomy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Partial Claviclectomy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Acromioplasty surgery.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, Acromioplasty Surgery, which includes bursectomy, recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 10/31/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 10/31/14 does not demonstrate evidence satisfying the above criteria. Therefore, the Left shoulder bursectomy is not medically necessary.

**Left shoulder possible biceps tenotomy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Partial Claviculectomy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Tenodesis long head of biceps.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, Acromioplasty Surgery, which includes bursectomy, recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 10/31/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 10/31/14 does not demonstrate evidence satisfying the above criteria. Therefore, the Left shoulder possible biceps tenotomy is not medically necessary.

**Medical clearance with the internal medicine physician:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Preoperative Testing

**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.