

<b>Case Number:</b>	CM15-0007320		
<b>Date Assigned:</b>	01/22/2015	<b>Date of Injury:</b>	06/03/2014
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	12/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York, New Hampshire, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 58 year old male who sustained an industrial related injury on 6/3/14. The injured worker had complaints of bilateral shoulder pain. Treatment included a left shoulder Cortisone injection. A MRI of the left shoulder obtained on 7/31/14 was noted to have revealed a low to moderate grade partial thickness articular sided tear of the leading edge of the supraspinatus tendon, separation of the anterosuperior labrum that may represent normal sublabral foramen versus labral tear and moderate acromioclavicular joint osteoarthritis with small subacromial enthesophyte. Diagnoses included a left shoulder SLAP lesion with paralabral cyst, and a 30% partial thickness supraspinatus tendon tear and a right shoulder rotator cuff tear. The injured worker had a history of a right shoulder rotator cuff repair and clavicle fracture. The physician noted the injured worker had failed physical therapy for the left shoulder. The treating physician requested authorization for a left shoulder arthroscopy endoscopic subacromial decompression and biceps tenodesis with debridement of repair and associated surgical services including an electrocardiogram, Labs: (CBC, CMP, PT, and PTT), physical therapy quantity 12, and Norco 10/325mg #60. On 12/17/14 the requests were non-certified. Regarding left shoulder arthroscopy endoscopic subacromial decompression and biceps tenodesis with debridement of repair the utilization review (UR) physician cited the Medical Treatment Utilization Schedule guidelines and Official Disability Guidelines. The UR physician noted the injured worker has full range of motion and was doing regular work. Surgery has not been shown superior to conservative care for partial rotator cuff tears. Therefore

the request was non-certified. Due to the surgery being non-certified the associated surgical services were also non-certified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Left shoulder arthroscopy Endoscopic Subacromial Decompression and Biceps Tenodesis with Debridement of Repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines Diagnostic Arthroscopy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-220.

**Decision rationale:** 58 yo male with chronic right shoulder pain. There is no documentation of loss of motion. No documentation of full thickness rotator cuff tear. MTUS indications for shoulder surgery not met. Shoulder surgery is not more effective than conservative measures. Surgery not medically needed.

**Associated surgical service EKG: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service Labs: CBC, CMP, PT, PTT: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service Physical Therapy Quantity 12: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Norco 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80, 81, 83, 98.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 86-87.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.