

<b>Case Number:</b>	CM15-0009136		
<b>Date Assigned:</b>	01/27/2015	<b>Date of Injury:</b>	02/06/2013
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2015

### 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  
 Certification(s)/Specialty: Neurological 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:

This 55 year old female sustained an industrial injury on 02/06/2013. The injured worker was diagnosed with chronic impingement to the right shoulder with type III acromion and acromioclavicular joint arthritis. The MRI of her shoulder on 04/30/2013 showed a rotator cuff tear with several mm of retraction of the posterior fibers of the supraspinatus tendon. On 09/19/2013 she had an arthroscopic subacromial decompression with distal clavicle excision and a mini-open rotator cuff repair. On 04/10/2014, she had a manipulation under anesthesia (MUA) and a corticosteroid injection for adhesive capsulitis. On 04/18/14 her postoperative magnetic resonance imaging showed a type I acromion, status post Mumford procedure and debridement, rotator cuff re-tear confirmed on magnetic resonance imaging, and frozen shoulder with status post manipulation under anesthesia. The PR2 of 06/24/2014 noted her shoulder abduction and flexion to be at 110 degrees with zero external rotation. Atrophy of her supraspinatus muscle was noted. She had positive Neer's and Hawkins and Jobe tests with point tenderness over the AC joint. Treatment to date has included physical therapy, above listed surgical procedures, above listed diagnostic studies, an oral medication regimen, and use of heat and ice. Currently, the injured worker complains of moderate right arm pain that radiates to the lower back and neck with stiffness and weakness. The pain is rated an eight on a scale of one to ten. On 01/08/2015 Utilization Review non-certified the requests for right shoulder arthroscopic acromioplasty, rotator cuff repair, and distal clavicle resection; post-operative physical therapy three times a week for four weeks for a total of twelve sessions; cold therapy; Ultrasling; and shoulder continuous passive motion, noting the California Medical Treatment Utilization Schedule,

American College of Occupational and Environmental Medicine, Chapter 9, Shoulder regarding Surgical Considerations.

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

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

#### **Right Shoulder Arthroscopic Acromioplasty, Rotator Cuff Repair and Distal Clavicle Resection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter-Surgery for impingement syndrome.

**Decision rationale:** According to the ODG guidelines an acromioplasty is not recommended in conjunction with a rotator cuff repair. Moreover, according to documentation this patient had already had an arthroscopic subacromial decompression in 2013. According to the ODG guidelines the outcomes of rotator cuff repair is not improved by acromioplasty. Thus the requested treatment: Right shoulder arthroscopic acromioplasty, rotator cuff repair and distal clavicle resection is not medically necessary and appropriate.

#### **Post-Operative Physical Therapy; Twelve (12) sessions, Three (3) times per week for four (4) weeks: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Right shoulder arthroscopic acromioplasty, rotator cuff repair and distal clavicle resection is not medically necessary and appropriate, then the Requested Treatment: Post-Operative Physical Therapy; Twelve (12) sessions, Three (3) times per week for four (4) weeks is not medically necessary and appropriate.

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

#### **Associated surgical service: Cold therapy: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Right shoulder

arthroscopic acromioplasty, rotator cuff repair and distal clavicle resection is not medically necessary and appropriate, then the Requested Treatment: Associated surgical service: cold therapy is not medically necessary and appropriate.

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

**Associated surgical service: Ultrasling: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Right shoulder arthroscopic acromioplasty, rotator cuff repair and distal clavicle resection is not medically necessary and appropriate, then the Requested Treatment: Associated surgical service: Ultrasling is not medically necessary and appropriate.

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

**Associated surgical service: Shoulder CPM: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Right shoulder arthroscopic acromioplasty, rotator cuff repair and distal clavicle resection is not medically necessary and appropriate, then the Requested Treatment: Associated surgical service: Shoulder CPM is not medically necessary and appropriate.

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