

<b>Case Number:</b>	CM15-0009370		
<b>Date Assigned:</b>	01/27/2015	<b>Date of Injury:</b>	10/28/2012
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/12/2014
<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: Illinois, California, Texas  
 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 51-year-old male, with a reported date of injury of 10/28/2012. The diagnoses include status post shoulder arthroscopy with subacromial decompression with persistent pain and stiffness of the shoulder and other affections of the shoulder region. Treatments have included MRI of the right upper extremity on 02/04/2014, which showed supraspinatus tendon articular-sided attenuation, possible full-thickness tear of the mid tendon fibers, mild infraspinatus and biceps long head tendinosis, anterosuperior labral irregularity, and mild acromioclavicular joint osteoarthritis; an MRI of the right upper extremity joint on 03/01/2013; right shoulder surgery on 06/05/2013; physical therapy; anti-inflammatory medications; multiple injections; and a work hardening program. The progress report dated 12/02/2014 indicates that the injured worker complained of persistent pain in the right shoulder. He had trouble with overhead activity and pain with sleeping on the shoulder. An examination of the right shoulder showed preserved anatomical alignment of the shoulder, well-healed surgical portal sites, palpation over the acromioclavicular joint and greater tuberosity of the shoulder was painless, no tenderness in the subacromial space of the shoulder to palpation, restricted shoulder motion, decreased range of motion, and no glenohumeral instability. The treating physician requested a repeat shoulder arthroscopy with possible cuff repair and postoperative physical therapy. On 12/12/2014, Utilization Review (UR) denied the request for a repeat right shoulder arthroscopy with rotator cuff repair and postoperative physical therapy evaluation and treatment three times a week for four weeks. The UR physician noted a lack of any recent treatment and no significant new injury or apparent change since the time the injured

worker was made permanent and stationary. The UR physician also noted that since the surgery was non-certified, the physical therapy is non-certified. The MTUS Chronic Pain Guidelines and ACOEM Guidelines were cited.

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

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

#### **Repeat Right Shoulder Arthroscopy with Rotator Cuff Repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The California MTUS guidelines state that for partial-thickness and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for 3 months. Surgery was not indicated for patients with mild symptoms or those whose activities are not limited. Guideline criteria have not been met. The patient reported a recent increase in right shoulder pain with positive impingement sign. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request for repeat right shoulder arthroscopy with rotator cuff repair is not medically necessary.

#### **Post-Op Physical Therapy Evaluate and Treatment 3 times 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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