

<b>Case Number:</b>	CM15-0019342		
<b>Date Assigned:</b>	03/16/2015	<b>Date of Injury:</b>	06/27/2011
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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 57-year-old female who sustained an industrial injury on 6/27/11. The mechanism of injury was not documented. Past surgical history was positive for right shoulder rotator cuff repair x 2. She underwent right shoulder arthroscopy with revision rotator cuff repair on 5/13/14. The 10/19/14 right shoulder MRI impression documented a 2x2 mm defect of the distal anterior supraspinatus tendon which could be the patient's post-operative state or a small recurrent focal tear. The tendon immediately adjacent to the suture anchors is intact. Consideration of MR arthrogram was recommended for further delineation. The 11/6/14 treating physician report indicated that the patient was doing poorly, with persistent weakness of her right shoulder with pain on overhead activities. Physical exam documented marked weakness of the shoulder to external rotation with a positive impingement sign. Imaging showed a full thickness rotator cuff tear. The injured worker had been treated appropriately with the allotted amount of physical therapy, multiple injections, medications, sling immobilization and rest, but remains symptomatic. Authorization was requested for diagnostic and operative arthroscopy of the right shoulder with rotator cuff repair. The 11/24/14 treating physician report cited continued right shoulder, neck and back pain. Physical exam noted loss of strength in internal and external rotation. MRI evidenced a complete tear of the rotator cuff. Right shoulder arthroscopy with rotator cuff repair was requested. A right shoulder corticosteroid injection was administered. The 1/09/15 treating physician report indicated that the injured worker returned from being out of the country with continued right upper arm pain. She was to start physical therapy on Monday. X-rays of the right shoulder showed no increase in osteoarthritis. The treatment plan included

tramadol and multiple topical creams. Authorization for right shoulder rotator cuff repair for completer rotator cuff tear was requested. On 1/22/15, the provider requested authorization for right shoulder surgery and associated surgical services. The 1/28/15 utilization review non-certified the request for right shoulder surgery and associated services/items as there was no clear imaging evidence of a new rotator cuff tear or clinical exam findings consistent with AC joint tenderness.

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

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

**Right shoulder with repair of small rotator cuff tear and Mumford procedure, anchors and screws:** Upheld

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

**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: Surgery for rotator cuff repair; Partial claviclectomy.

**Decision rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines for rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment, plus painful arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, rotator cuff or anterior acromial tenderness, and positive impingement sign with a positive diagnostic injection test. Criteria include imaging evidence of a rotator cuff deficit. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have not been met. This patient presents status post two prior rotator cuff repairs with right shoulder pain. Current clinical exam findings were not documented. A corticosteroid injection was provided on 11/24/14 with no follow-up report of response. Imaging findings showed a small supraspinatus defect that could be consistent with the injured worker's post-operative status. MR arthrogram was recommended for further evaluation, but there is no indication that additional imaging was performed. The patient was reported as beginning physical therapy. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Given the failure to clearly meet guideline criteria relative to imaging evidence and failure conservative treatment, this request is not medically necessary.

**Associated surgical services: assistant surgeon: 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 Centers for Medicare and Medicaid services. Physician Fee Schedule: Assistant Surgeons <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary

**Pre-op medical clearance labs: CBC, CMP, PT/PTT and UA: 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 Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Pre-op medical clearance: EKG: 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 Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Pre-op medical clearance: Chest x-ray: 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 Practice advisory for preanesthesia evaluation: an

updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Post-op PT, 3x4, right shoulder:** Upheld

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

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

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Associated surgical service: Cold therapy unit purchase:** 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 Official Disability Guidelines (ODG) Shoulder: Continuous flow cryotherapy.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Associated surgical service: Shoulder sling:** 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): 205 and 213.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Associated surgical service: Pain pump purchase:** 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 Official Disability Guidelines (ODG) Shoulder: Postoperative pain pump.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Associated surgical service: IF unit 1-2 month rental:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.