

<b>Case Number:</b>	CM15-0134295		
<b>Date Assigned:</b>	07/28/2015	<b>Date of Injury:</b>	01/08/2013
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	06/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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: California, Indiana, Oregon  
 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 56-year-old male, who sustained an industrial injury on 1/8/13. Initial complaints were of both shoulder injuries. The injured worker was diagnosed as having rotator cuff tear. Treatment to date has included status post left shoulder arthroscopy rotator cuff repair, coracoacromial ligament release, Mumford procedure (1/10/14); physical therapy; medications. Diagnostics studies included EMG/NCV study lower extremities (2/6/15); MRI left shoulder (2/11/15). Currently, the PR-2 notes dated 3/31/15 indicated the injured worker presented for a re-evaluation of ongoing complains regarding his left shoulder. He is now 14 months status post left shoulder arthroscopy rotator cuff repair, coracoacromial ligament release, Mumford procedure on 1/10/14. Clinically, the provider notes, he has full range of motion but is tender over the biceps with pain on Speed's testing and negative belly press test. His pain seems to be in the area of his biceps. The provider reviewed his MRI. On 2/11/15, a MRI of the left shoulder was completed with an impression of intact rotator cuff with interstitial degeneration and mild medial subluxation of the biceps tendon and interstitial tear of the distal capsularis which is 1.3cm in length with abnormal pulley as the morphology of the superior glenohumeral ligament is regular. There is an intact inferior glenohumeral ligament labral complex with mild spurring of the glenoid rim. There was also an EMG/NCV study of the lower extremities dated 2/6/15, although this was not the focus of this dates complaints. The interpretation notes chronic re-nervation changes were seen in the left L5-S1 innervated muscles, indicative of a previous injury. There is electrical evidence on this examination to suggest chronic re-innervation change involving the left L5-S1 innervated muscles. There is no electrical evidence of active radiculopathy, plexopathy or other focal or generalized neuropathy involving the lower limbs to explain the symptoms. The injured worker has a cortisone injection on his last visit and has had extensive physical therapy. The supraspinatus repair is intact but he does not want to live with this pain and cannot return to work in this condition without additional treatment. The provider

is requesting authorization of repeat left shoulder arthroscopy; postoperative left shoulder brace; postoperative hot/cold therapy left shoulder and postoperative physical therapy 6 sessions for the left shoulder.

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

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

#### **Repeat Left Shoulder Arthroscopy: 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.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of diagnostic shoulder arthroscopy. Per ODG shoulder, the criteria to consider diagnostic arthroscopy of the knee are: 1. Conservative Care (medications or PT); 2. Subjective clinical findings; 3. Imaging findings. In this case, there is no recent imaging demonstrating surgical pathology or equivocal findings. The request is not medically necessary.

#### **Post-operative Left Shoulder Brace: 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.

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

#### **Post-operative Hot/Cold Therapy Left Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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

#### **Post-op physical therapy 2-3 x 6 for the left shoulder: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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