

<b>Case Number:</b>	CM15-0134401		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	01/23/2015
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	06/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/13/2015

### 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: Minnesota, Florida

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 68 year old male, who sustained an industrial injury on 1-23-15. Initial complaint was a pop in his left shoulder followed by pain. He had undergone surgery on the left shoulder 15 years ago. An MR Arthrogram of November 2014 had revealed a retracted massive rotator cuff tear and degenerative arthritis of the left shoulder. Progress notes from 12/2/2014 indicate an injury to the right shoulder one week ago. The mechanism of the right shoulder injury has not been documented. Treatment to date has included right shoulder arthroscopy debridement of anterior superior labrum SLAP type 3, multiple tears, chondroplasty, acromioplasty, open Mumford procedure and repair of rotator cuff; injection of right shoulder (1-29-15); post-op physical therapy; urine drug screening; medications. Diagnostics studies included MR Arthrogram left and right shoulders (11/12/2014 and 12/10/2014). He has ankle edema, history of cardiomyopathy, hypertension, no tingling, no numbness, no chest pressure or palpitations at present and no syncope. He has been diagnosed with bilateral shoulder pain; acute coronary occlusion without myocardial infarction; obstructive chronic bronchitis with acute exacerbation and benign essential hypertension. He is now on this date status post right shoulder arthroscopy debridement of anterior superior labrum SLAP type 3, multiple tears, chondroplasty, acromioplasty, open Mumford procedure and repair of rotator cuff; injection of right shoulder performed on 1-29-15. The provider is requesting authorization of Retro - Right shoulder arthroscopy, debridement of anterior superior labrum, bicipital tendon debridement for multiple tears, chondroplasty, acromioplasty, open Mumford procedure, RTC repair and associated surgical service: Retro - Right shoulder injection all for date of service 1-29-15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro - Right shoulder arthroscopy, debridement of anterior superior labrum, bicipital tendon debridement of the multiple tears, chondroplasty, acromioplasty, open Mumford procedure, RTC repair: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topics: Acromioplasty, SLAP repair, Partial claviclectomy, chondroplasty.

**Decision rationale:** A review of the medical records indicates a history of bilateral shoulder pain. There was a past history of surgery on the left shoulder 15 years ago with continuing pain. An MR arthrogram of the left shoulder was performed on 11/12/2014. The left shoulder was deemed irreparable due to a massive chronic retracted rotator cuff tear and severe degenerative changes. A reverse shoulder replacement was advised for the left shoulder. However, on the right side the injured worker was complaining of pain and examination revealed impingement. The MR Arthrogram of the right shoulder was performed on 12/10/2014. This revealed a 13 x 19 mm transverse full-thickness tear of the subscapularis and anterior supraspinatus fibers at the level of the critical zone. There was moderate grade subacromial/subdeltoid bursitis. The long head of the biceps tendon was dislocated medially from the bicipital groove. The acromion was type II and there was moderate acromioclavicular arthritis present. There was resultant mass effect upon the underlying supraspinatus tendon. The documentation indicates one corticosteroid injection into the right shoulder for pain relief prior to the operative procedure of 1/29/2015. However, no other conservative treatment has been documented. California MTUS guidelines indicate a rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. Although the provider is not documenting the range of motion, he has documented presence of impingement on examination as well as pain. The findings are corroborated by the imaging findings of a full-thickness rotator cuff tear, MRI evidence of impingement and moderate acromioclavicular arthritis with osteophyte formation causing a mass effect on the underlying rotator cuff. Although preoperative physical therapy has not been documented, a corticosteroid injection was given but the result is not known. A detailed preoperative examination including range of motion and functional impairment demonstrating the need for the surgical procedures has not been submitted. With regard to the acromioplasty ODG guidelines again necessitate documented failure of conservative treatment before surgery. For labral debridement and partial claviclectomy the guidelines also recommend trial/failure of conservative treatment for 6 weeks. For chondroplasty a chondral defect should be documented on the imaging studies. Absent the above guideline necessitated documentation the medical necessity of the requested surgical procedures has not been substantiated.

**Associated surgical service: Retro - Right shoulder injection: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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