

<b>Case Number:</b>	CM15-0161259		
<b>Date Assigned:</b>	08/28/2015	<b>Date of Injury:</b>	11/26/2007
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	07/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2015

### 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 60 year old female, who sustained an industrial injury on 11-26-07. The injured worker was diagnosed as having chronic cervical strain with myofascitis, status post arthroscopy of right shoulder for subacromial decompression and distal clavicle resection and right shoulder partial thickness tear of the supraspinatus tendon without evidence of full thickness tear, right shoulder partial thickness tear of supraspinatus tendon at insertion and inferior surface tear proximal to its insertion, right hand pain and paresthesias and stress, anxiety and depression. Treatment to date has included right shoulder arthroscopy, injection of right shoulder, physical therapy, acupuncture and oral medications including Norco and Mobic. (MRI) magnetic resonance imaging of right shoulder performed on 6-23-25 revealed partial thickness tear of the supraspinatus tendon at its insertion and an inferior surface tear, small amount of fluid in the subacromial arch and sub coracoid and fluid within the biceps tendon sheath. Currently on 7-17-15, the injured worker complains of constant right sided neck-upper back pain with associated headaches with painful movement and tingling in right arm; she also complains of right shoulder pain which is constant with right upper extremity weakness and painful movement. She is currently not working. Physical exam performed on 7-17-15 revealed tenderness to palpation over the anterior and superior aspects of right shoulder with painful and limited range of motion and exam of right hand revealed normal color and temperature. A request for authorization was submitted on 7-22-15 for Mobic 7.5 mg #30, Norco 5mg #60, right shoulder revision arthroscopy with subacromial decompression and distal clavicle resection and possible rotator cuff repair and pre-operative medical clearance with an internist, cold

therapy unit rental for 10 days, 12 sessions of postoperative physical therapy to right shoulder, and a sling.

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

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

**Right shoulder revision arthroscopy for subacromial decompression and distal clavicle resection and possible rotator cuff repair: 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:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the imaging does not demonstrate full thickness rotator cuff tear. The request is not medically necessary.

**Pre-op medical clearance w/an internist: 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.

**Post-op physical therapy X 12 sessions: 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.

**Mobic 7.5mg #30:** 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.

**Norco 5/325mg #60:** 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.

**Associated surgical services: Sling:** 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.

**Cold therapy unit, rental 10 days:** 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.