

<b>Case Number:</b>	CM15-0180678		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	06/02/2015
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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:

This is a 55-year-old male worker with a date of injury 6-2-2015. The medical records indicated the injured worker (IW) was treated for rotator cuff tear, right. In the 7-2-15 and 8-7-15 progress notes, the IW reported right shoulder pain and right heel and ankle pain. Pain score most recently was 8 out of 10. He reported his symptoms and function had not improved since his last visit. He stated he had returned to work with restrictions since his last visit. Objective findings on 7-2-15 and 8-7-15 included decreased range of motion of the right shoulder with tenderness and pain on motion. Treatments included home exercise program. The treatment plan included physical therapy for the right shoulder and possible surgery. MRI of the right shoulder on 6-23-15 showed a massive-type rotator cuff tear and a biceps tendon tear. A Request for Authorization dated 7-14-15 was received for right shoulder arthroscopy, post-op physical therapy twice or three times a week for nine weeks for the right shoulder (12); post-op shoulder sling and cold therapy unit. The Utilization Review on 8-20-15 non-certified the request for right shoulder arthroscopy for lack of diagnostic imaging (MRI); post-op physical therapy twice or three times a week for nine weeks for the right shoulder (12), post-op shoulder sling and cold therapy unit were non-certified, as they are associated services of the non-certified surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-op Physical Therapy 2-3xwk x 9wks for right shoulder:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Right Shoulder Arthroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment for Workers Compensation Online Edition (2015).

**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 and 210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the records do not demonstrate evidence satisfying the above criteria notably the 3-6 of documented conservative care. Therefore the request does not adhere to guideline recommendations and is not medically necessary.

**Associated surgical service: Cold therapy unit:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Post-op shoulder 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.