

<b>Case Number:</b>	CM15-0081193		
<b>Date Assigned:</b>	05/01/2015	<b>Date of Injury:</b>	03/01/2013
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	04/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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 64-year-old female, who sustained an industrial injury on 3/1/13. She reported a right shoulder injury and neck injury. The injured worker was diagnosed as having left shoulder rotator cuff tear, subacromial impingement and osteoarthritis and degenerative joint disease. Treatment to date has included oral medications, transdermal medications, physical therapy, acupuncture, activity restrictions and home exercise program. Currently, the injured worker complains of progressive left shoulder pain. Physical exam noted tenderness to palpation at the AC joint and pain with cross adduction. The treatment plan included scheduling for arthroscopic surgery of left shoulder. A request for authorization was submitted for left shoulder arthroscopy rotator cuff repair, subacromial decompression, distal clavicle excision, pre-op clearance, physical therapy, ultra sling and cold therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy, rotator cuff repair, subacromial decompression, and distal clavicle excision:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, 213. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Mumford procedure.

**Decision rationale:** The injured worker is a 64-year-old female sustained a repetitive trauma injury to the neck and right shoulder on 3/1/2013. Prior treatment included a right shoulder arthroscopy with subacromial decompression and excision of lateral clavicle. The current request pertains to the left shoulder. MRI of the left shoulder performed on 2/26/2015 documented partial-thickness tearing of the mid supraspinatus tendon 3 x 3 mm and 2 mm x 3 mm tear of the anterior to mid supraspinatus tendon footprint. There was interval resolution of a small subscapularis tendon low-grade partial-thickness tear with mild subscapularis tendinosis compared to a prior study of 2013. The acromioclavicular joint was normal. On examination per 4/15/2015 documentation impingement testing was positive and there was tenderness over the acromioclavicular joint. A request for left shoulder arthroscopy with rotator cuff repair, subacromial decompression and lateral clavicle excision was noncertified by utilization review. Due to lack of documentation of at least 3 months of physical therapy as recommended by guidelines for impingement syndrome. The MRI findings pertaining to the acromioclavicular joint are documented in the report dated 2/26/2015. The AC joint alignment was anatomic without degenerative change. Furthermore the acromion was type I. California MTUS guidelines indicate the surgery for impingement syndrome is usually arthroscopic decompression. Conservative care including corticosteroid injections can be carried out for at least 3-6 months before considering surgery. 2 or 3 injections over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears are recommended. The documentation provided does not include evidence of a recent trial/failure of such an exercise rehabilitation program combined with injections. California MTUS guidelines also state that for partial-thickness rotator cuff tears surgery is reserved for cases failing conservative therapy for 3 months. Furthermore, the request for lateral claviculectomy is not supported as the MRI scan report of 2/26/2015 documents anatomic alignment of the acromioclavicular joint without degenerative change. ODG guidelines for lateral claviculectomy include imaging clinical findings of posttraumatic changes of acromioclavicular joint or severe degenerative joint disease of the acromioclavicular joint or acromioclavicular separation. The MRI findings noted above do not support the request for partial claviculectomy. As such, the requests for arthroscopy of the left shoulder with subacromial decompression, rotator cuff repair, and lateral claviculectomy are not supported and the medical necessity of the requests has not been substantiated.

**Associated surgical service: preop clearance with history and physical, CXR, CBC, BMP, EKG and PT/PTT:** 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 service: Physical therapy 2 times a week for 6 weeks:** 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 surgical procedure is not medically necessary, none of the associated surgical requests are medically necessary.

**Associated surgical service: Ultra 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 surgical procedure is not medically necessary, none of the associated surgical requests are medically necessary.

**Associated surgical service: Cold therapy, 1 week:** 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): 210, 211, 213.

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