

<b>Case Number:</b>	CM14-0128142		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	03/31/2012
<b>Decision Date:</b>	12/16/2014	<b>UR Denial Date:</b>	07/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and Hand Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 38-year-old female with a reported date of injury of 03/31/2012. The mechanism of injury was not specifically stated. The current diagnoses include status post labral repair and subacromial decompression, and rotator cuff tear. The injured worker was evaluated on 05/14/2014. Previous conservative treatment is noted to include medication management and physical therapy. There was no physical examination provided on that date. Treatment recommendations included rotator cuff repair. There was no Request for Authorization Form submitted for review. It is noted that the injured worker underwent an MRI of the right shoulder on 05/02/2014, which revealed evidence of a mild to moderate heterogeneous signal alteration and thickening of the rotator cuff with chronic tendinopathy involving the supraspinatus, infraspinatus, and subscapularis tendons.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Right Shoulder Rotator Cuff Repair: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC, Corpus Christi, TX, www.odg-twc.com Section; Shoulder (acute & chronic) updated 4/25/2014)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 209-210.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation. As per the documentation submitted, the injured worker has been previously treated with medications and physical therapy. However, there is no documentation of a recent physical examination. There is no evidence of a significant functional limitation. Therefore, the current request cannot be determined as medically necessary and appropriate at this time.

**Associated surgical service: Right Shoulder Arthrogram:** 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: Pre-Op Clearance:** 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: Post- op Therapy X 6 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.