

<b>Case Number:</b>	CM14-0161309		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	05/26/2010
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	09/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 is licensed to practice in California. 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 claimant is a 53-year old male who sustained a vocational injury on 05/26/10. The medical records provided for review included the office note dated 08/28/14. Physical examination revealed positive tenderness of the right acromioclavicular joint, normal range of motion of the bilateral upper extremities, and a positive cross-over and Hawkin's testing of the right shoulder. It was documented that the claimant had failed conservative care. The report of an MRI of the right shoulder dated 08/18/14 identified a Type 2 acromion with lateral acromial downslope. There was a lateral acromial margin spur apparently impinging on the supraspinatus. There are degenerative changes in the acromial clavicular joint with inferior spurring and minimal impingement upon the supraspinatus. There was diffuse supraspinatus tendinopathy and a small partial tear noted at the anterior tuberosity insertion. There was tendinopathy of the subscapularis. There are degenerative changes of the glenohumeral joint with suspected degeneration of the labrum and possible superior and posterior regions of tearing. The current request is for a right shoulder arthroscopic subscapularis rotator cuff repair. In addition, there is also a request for surgical intervention in the form of a right shoulder subacromial Decompression and distal clavicle resection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopic Subscapularis Rotator Cuff Repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Surgery for rotator cuff repair

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** California ACOEM Guidelines recommend that prior to considering surgical intervention for partial thickness rotator cuff tear and impingement syndrome, the documentation should establish the claimant has had a minimum of three (3) to six (6) months of continuous conservative treatment to include injection therapy, formal physical therapy, home exercise program, activity modification, and anti-inflammatories. Although documentation suggests the claimant has failed conservative care, there is no documentation supporting the exact nature of the conservative care nor the quantity or response to previous conservative care to date prior to considering and recommending surgical intervention. Therefore, based on the documentation presented for review in accordance with California ACOEM Guidelines, the request for the right shoulder arthroscopic subscapularis rotator cuff repair and subacromial decompression and distal clavicle resection could not be considered medically necessary based on documentation presented for review.

**Subacromial Decompression, and Distal Clavicle Resection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Surgery for rotator cuff repair

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** California ACOEM Guidelines recommend that prior to considering surgical intervention for partial thickness rotator cuff tear and impingement syndrome, the documentation should establish the claimant has had a minimum of three (3) to six (6) months of continuous conservative treatment to include injection therapy, formal physical therapy, home exercise program, activity modification, and anti-inflammatories. Although documentation suggests the claimant has failed conservative care, there is no documentation supporting the exact nature of the conservative care nor the quantity or response to previous conservative care to date prior to considering and recommending surgical intervention. Therefore, based on the documentation presented for review in accordance with California ACOEM Guidelines, the request for the right shoulder arthroscopic subscapularis rotator cuff repair and subacromial decompression and distal clavicle resection could not be considered medically necessary based on documentation presented for review.

**Post-Op Physical Therapy 3x6 visits: 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.

**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:** 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.