

<b>Case Number:</b>	CM14-0180710		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	02/09/2013
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	10/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2014

### 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:

59 year old male claimant with an industrial injury dated 02/09/13. The patient is status post right endoscopic carpal tunnel release as of 05/23/13. The patient is also status post a right shoulder arthroscopy, acromioplasty, biceps tendon tenodesis, Mumford procedure, lysis of adhesions with subacromial bursectomy, partial synovectomy, and arthrotomy of the right shoulder with rotator cuff repair and removal of loose bodies as of 04/08/14. Exam note 09/18/14 states the patient returns with left shoulder pain and stiffness. The patient explains his satisfaction with the right shoulder surgery and wishes to continue with one for the left. Exam note 10/08/14 states the patient continues to have shoulder pain. Upon physical exam there was evidence of tenderness, atrophy, and weakness of the shoulder. The patient demonstrated a painful range of motion, and absent abduction. The patient had increased pain at night. The patient has completed 12 postoperative physical therapy sessions. Treatment includes left shoulder surgery, additional physical therapy, a shoulder sling, and a cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OPA left shoulder PASTA repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, 209, 210-211, 214. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation: Surgery for rotator cuff

repair Official Disability Guidelines - Surgery for impingement syndrome; Indications for Surgery--Acromioplasty

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff repair

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 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 submitted notes from 10/8/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 10/8/14 does not demonstrate night pain or relief from anesthetic injection. Therefore the request is not medically necessary.

**Associated surgical service: Assistant surgeon:** 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: Postop PT 3 times per week for 4 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 procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Medical clearance exam includes CBC, CMP, PT/PTT, UE, EKG, Chest X-ray:** 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: Cold therapy unit purchase:** 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: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Pain Pump:** 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.