

<b>Case Number:</b>	CM14-0215408		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	05/02/2013
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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. 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: New York  
 Certification(s)/Specialty: Neurological 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 64 year old male has a date of injury 05-02-13. Documentation does not describe the mechanism. Past Medical history includes bilateral knee replacements, fractured right elbow 1984, hypercholesterolemia and hyperthyroidism. On 2/10/2014 the injured worker underwent right shoulder arthroscopy, rotator cuff repair, chondroplasty of humeral head and glenoid with subscapularis repair, distal clavicle resection, acromioplasty, subacromial bursectomy and a biceps tenodesis. Post-operative physical therapy was authorized. In followup visits a home exercise program was recommended as well as NSAIDS medication. In the followup visit note of 07/30/2014 his symptoms and range of motion (ROM) were stated to have improved. Active abduction was noted to be 0-150 degrees, internal and external rotation 0-60 with muscle strength of the shoulder muscles at 4/5. Home exercise program was recommended. On the visit of 10/01/2014 his symptoms were noted to have improved with unchanged weakness and forward flexion was 0-160, with abduction, internal and external rotation unchanged. A followup MRI scan of the shoulder on 10/21/2014 showed a recurrent full thickness tearing of the repaired supraspinatus tendon as well as the subscapular tendon. The injured worker on 11/26/2014 noted continued pain and crepitus in the right shoulder with no change in the strength and range of motion. Utilization Review of 12/08/2014 denied the request for revision right shoulder rotator cuff repair, the services of a surgical assistant, purchase of a cold therapy unit, and rental of CPM, post-op abduction sling, post-operative Percocet 5-325 #60, and post-operative physical therapy 12 sessions.

## 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 (revision): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Shoulder Chapter

**Decision rationale:** Guidelines note that results from rotator cuff revision surgery are inferior to those of primary repair. The injured worker's documentation had indicated improvement in symptoms and range of motion while strength was unchanged but had not worsened. Surgery indications include inability to elevate the arm which the worker can do. As the injured worker had not been pursuing a continuous exercise program prior to his June visit, and documentation does not show details and results of the home exercise program, guidelines are not met.

**Surgery assist- PA-C for right shoulder surgery: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross/Blue Shield North Carolina, Corporate Medical Policy, Co-Surgeon, Assistant Surgeon, and Assistant-at-Surgery Guidelines, File Name: co-surgeon\_assistant\_surgeon\_and assistant\_at\_surgery guidelines, Origination: 01/2000, Last Review: 07/2009, Next Review: 07/2010

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation see below

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

**Postoperative Continuous Passive Motion (CPM) rental times 14 days for the right shoulder: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Chapter, Continuous passive motion (CPM)

**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.

**Postoperative cold therapy unit - purchase for the right shoulder: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Chapter, Continuous-flow cryotherapy

**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.

**Postoperative abduction sling for the right shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Postoperative abduction pillow sling

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation see below

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

**Postoperative pain medications - Percocet 5-325mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2004 OMPG, Initial Approaches to Treatment ch 3, page 47-48

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation see below

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

**Postoperative physical therapy times 12 sessions for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation see below

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