

<b>Case Number:</b>	CM15-0123208		
<b>Date Assigned:</b>	07/07/2015	<b>Date of Injury:</b>	05/09/2013
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	06/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2015

### 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: California, Indiana, Oregon  
 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 58 year old female, who sustained an industrial injury on 5/09/2013. Diagnoses include full thickness rotator cuff tear with retraction. Treatment to date has included conservative care including medications, physical therapy, activity modification, homer exercise and injections. Per the Primary Comprehensive Orthopedic Consultation dated 3/13/2015, the injured worker reported right shoulder pain rated as 9/10 in severity. Physical examination of the right shoulder revealed positive impingement tests, Range of motion as restricted in forward flexion, extension, abduction and adduction. The diagnostic ultrasound of the right shoulder dated 10/02/2014 confirmed the presence of a rotator cuff tear. The plan of care included surgical intervention and authorization was requested for arthroscopic right rotator cuff repair, decompression and distal clavicle resection, preoperative medical clearance, 12 postoperative rehabilitative therapy visits, one home continuous passive motion (CPM) machine, one shoulder immobilizer, one Surgi-stim unit, and one cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic Right Rotator Cuff Repair, Decompression and Distal Clavicle Resection:**  
 Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute & Chronic) - Rotator Cuff Repair; Acromioplasty; Surgery for Impingement Syndrome; Partial Claviclectomy.

**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.

**Decision rationale:** Based upon the CA MTUS Shoulder Chapter, pages 209-210, recommendations are made for surgical consultation when there are red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post-traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition, there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case, the exam note from 3/13/15 and the imaging findings from the same do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore, the request is not medically necessary.

**Associated surgical service: Continuous passive motion device (CPM) for home use, initial period 45 days: 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 (Acute & Chronic).

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

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

**Associated surgical service: 1 Surgi-stim unit for initial period of 90 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

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

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