

<b>Case Number:</b>	CM15-0176394		
<b>Date Assigned:</b>	09/17/2015	<b>Date of Injury:</b>	12/28/2007
<b>Decision Date:</b>	10/19/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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, Oregon, Washington  
 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 37-year-old female who sustained an industrial injury on 12-28-08. A review of the medical records indicates the injured worker is undergoing treatment for joint pain in the arm, and medial and lateral epicondylitis. Medical records (05-07-15) indicate the injured worker complains of new onset of right elbow as well as right shoulder pain with limited range of motion noted in both joints. The pain is not rated. The medical records (08-06-15) indicate the injured worker reports her symptoms have "worsened" since her last visit 6 weeks ago." The physical exam (08-06-15) reveals limited range of motion in the right shoulder as compared to the left. Treatment has included a right shoulder rotator cuff repair on 03-12-13, as well as medications, a right shoulder ultrasound guided cortisone injection, and physical therapy. The treating provider indicates the right shoulder MRI (04-30-15) reveals "intact biceps tenodesis in a subpectoral location and the components of the rotator cuff and glenoid labrum appear intact." The original utilization review (08-18-15) noncertified right shoulder arthroscopic rotator cuff repair, postoperative physical therapy and a sling.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopy/rotator cuff repair right shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder chapter, Indications for surgery - Acromioplasty.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, 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 physical exam from 8/6/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. The MRI from 4/30/15 failed to show a rotator cuff tear. Therefore, the determination is not medically necessary for the requested procedure.

**Post op physical therapy 2 times 6, 12 total 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Sling:** 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.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, surgery for rotator cuff repair.

**Decision rationale:** According to the California MTUS guidelines, Shoulder complaints Chapter 9 pages 212-214, it is recommended to use a brief use of the sling for severe shoulder pain (1-2 days) with pendulum exercises to prevent stiffness and cases of rotator cuff conditions, and prolonged use of the sling only for symptom control is not supported. In this case, the use of a shoulder sling would be contraindicated following right shoulder arthroscopy to prevent adhesive capsulitis. The request for a sling is therefore not medically necessary and appropriate. As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.