

<b>Case Number:</b>	CM15-0179002		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	01/22/2015
<b>Decision Date:</b>	10/22/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### 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 76 year old male, who sustained an industrial injury on January 22, 2015, incurring head, chest, abdomen, low back, right knee and right shoulder injuries. Chest x-ray was unremarkable. Computed tomography of the head revealed a subdural hematoma. Computed tomography of the spine showed severe degenerative joint disease with no fractures. Diagnostic imaging of the right shoulder revealed impingement syndrome. He was diagnosed with a right acromioclavicular joint sprain, right rotator cuff tear, right shoulder adhesive bursitis and right shoulder impingement syndrome and left knee chondromalacia. Treatment included physical therapy, pain medications, orthopedic consultation, neurology consultation and activity restrictions. Currently, the injured worker complained of persistent right shoulder pain with decreased range of motion and motor strength, and weakness and pain of the lower back radiating into the lower extremities interfering with his activities of daily living. He rated his shoulder pain 7 out of 10 on a pain scale from 1 to 10. His pain increased when reaching or lifting. The treatment plan that was requested for authorization on August 24, 2015, included a right shoulder mini open rotator cuff repair with arthroscopic subacromial decompression and debridement with distal clavicle excision; transcutaneous electrical stimulation unit trial for one month; and twelve post-operative physical therapy visits. On August 20, 2015, a request for a surgical arthroscopic rotator cuff repair was non-certified; a request for transcutaneous electrical stimulation unit was non-certified and a request for 12 post-operative physical therapy visits was non-certified by utilization review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder mini-open rotator cuff repair with arthroscopic subacromial decompression and debridement with distal clavicle excision:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

**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, acromioplasty, Partial Claviclectomy.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 209 and 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 do not demonstrate 4 months of failure of activity modification. The physical exam does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is for non-certification for the requested procedure. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam notes do not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is for non-certification. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for posttraumatic 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 notes and the imaging findings do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the request is not medically necessary.

**Associated surgical service: TENS unit trial for 1 month:** 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.

**Post-operative physical therapy visits Qty: 12:** 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.