

<b>Case Number:</b>	CM15-0045071		
<b>Date Assigned:</b>	03/17/2015	<b>Date of Injury:</b>	06/12/2014
<b>Decision Date:</b>	05/29/2015	<b>UR Denial Date:</b>	02/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2015

### 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

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 59 year old male, who sustained an industrial injury on June 12, 2014. The injured worker suffered a right upper extremity injury while cleaning a machine/piece of equipment. The injured worker was diagnosed as having cervical spine strain, right shoulder distal anterior supraspinatus tendon tear, right shoulder sprain, right elbow cubital tunnel syndrome, right wrist distal radius fracture, right wrist moderate carpal tunnel syndrome, right wrist open reduction internal fixation, status post debridement and irrigation of the right wrist and status post removal of external fixator of the right wrist and thoracic spine strain. Treatment to date has included radiographic imaging, diagnostic studies, multiple surgical interventions of the right wrist, medications and work restrictions. The injured worker presented on 01/14/2015 for a followup evaluation. The injured worker reported cervical spine pain, right shoulder pain, and right hand/wrist pain. There was numbness and tingling noted in the right hand/wrist. Upon examination of the right shoulder, there was tenderness at the AC joint, upper trapezius, subacromial bursa, biceps tendon, and pectoralis. There was a positive Neer's sign, negative Hawkins and Jobe test, and negative cross adduction and Speed's test. The physician indicated the MRI of the right shoulder dated 12/09/2014 was received and reviewed, the official imaging study was not provided for this review. Treatment recommendations at that time included a right carpal tunnel release, a right shoulder arthroscopic subacromial decompression, a right wrist brace, and a second opinion hand specialist. There was no Request for Authorization form submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 Right shoulder arthroscopic subacromial decompression with arthroscopic versus open repair of the rotator cuff tear: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 209-210.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion after exercise programs, and clear clinical and imaging evidence of a lesion. In this case, there was no comprehensive physical examination of the right shoulder provided. There is no evidence of a significant functional deficit. There was also no official imaging study provided for this review. Given the above, the request is not medically necessary.

### **Associated Surgical Service: 1 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.

### **Associate Surgical Service: 1 cold therapy unit: 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.

### **Associate Surgical Service: 32 post-operative physical therapy 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.