

<b>Case Number:</b>	CM15-0061480		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	05/14/2010
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2015

### 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 55 year old male who sustained a work related injury May 14, 2010. The mechanism of injury was repetitive motion. Past history included massive rotator cuff tear, s/p arthroscopy with debridement right shoulder December, 2013. According to a treating physician's progress report, dated February 25, 2015, a recent MRI dated February 18, 2015, reveals a functionally complete tear of the rotator cuff and supraspinatus tendon, with a distal supraspinatus tendon shredded tear measuring 1.5 x 1.3 cm with full thickness porous contrast communication with the subacromial subdeltoid space. The injured worker complains of continued pain, discomfort, and weakness in his left shoulder. Assessment is documented as massive retracted right shoulder rotator cuff tear and left shoulder rotator cuff tear. Treatment plan included request for authorization of left shoulder diagnostic and operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa and possible distal clavicle resection and rotator cuff repair and biceps tenodesis, medical clearance, physical therapy and post-operative sling. Prior treatments included medication, acupuncture, chiropractic care, and exercises.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Left shoulder diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa with possible distal clavicle resection and rotator cuff repair and biceps tenodesis: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Partial Claviculectomy.

**Decision rationale:** The ACOEM Guidelines indicate a surgical consultation may be appropriate for injured workers who have a failure to increase range of motion and strength of musculature in the shoulder after exercise programs and who have clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. For injured workers with a partial thickness or small full thickness tear, impingement surgery is reserved for cases failing conservative care therapy for 3 months and who have imaging evidence of rotator cuff deficit. For surgery for impingement syndrome, there should be documentation of conservative care including cortisone injections for 3 to 6 months before considering surgery. They do not however address Mumford resection. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that for a partial claviculectomy, there should be documentation of at least 6 weeks of care directed toward symptomatic care, plus pain at the AC joint and aggravation of pain with shoulder motion or carrying weight, plus there should be tenderness over the AC joint and pain relief with an injection of anesthetic for diagnostic therapeutic trial plus conventional films showing post-traumatic changes of the AC joint. The documentation indicated the injured worker was symptomatic with weakness in the left shoulder. The physical examination revealed a positive Neer's test, Hawkins test, and O'Brien's test of the left shoulder. The injured worker had crepitation of the subacromial space. The clinical documentation submitted for review indicated the injured worker had objective findings upon examination and had a type 2 acromion. The documentation failed to indicate the injured worker had conservative care for 3 to 6 months and the injured worker was noted to have a non-retracted shredded tear resulting in full thickness porous communication. The documentation indicated the injured worker had a rotator cuff that was not repaired due to a massive retraction with irreparable tear status post arthroscopic debridement on 12/09/2013. There was a lack of documented rationale to support that the injured worker would benefit from additional surgery. There was a lack of documented rationale as to why the surgical intervention would be appropriate at this time since the rotator cuff could not be repaired on 12/09/2013 due to retraction. Given the above, the request for 1 Left shoulder diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa with possible distal clavicle resection and rotator cuff repair and biceps tenodesis is not medically necessary.

**Associated surgical services: 12 Physical therapy sessions between 2/25/2015 and 5/16/2015: 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.

**Associated surgical services: 1 medical clearance:** 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.

**Associated surgical services: 1 Post-op sling between 2/25/2015 and 5/16/2015:** 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.