

<b>Case Number:</b>	CM15-0070761		
<b>Date Assigned:</b>	04/22/2015	<b>Date of Injury:</b>	12/26/2011
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2015

### 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 54 year old female, who sustained an industrial injury on December 26, 2011. The injured worker was diagnosed as having left foot/first toe sprain, rotator cuff tear, left knee meniscus tear, and right arm radiculopathy. Treatment to date has included physical therapy, MRIs, right shoulder surgery 2012, and medication. Currently, the injured worker complains of continued pain to the right shoulder, pain to the left shoulder, and pain to both knees. The Treating Physician's report dated March 6, 2015, noted the injured worker was doing physical therapy with the right shoulder with no relief. Physical examination of the shoulders was noted to show moderate tenderness over the right anterolateral border of the acromion, over the anterolateral border of the left acromion, and over the long head of the biceps on the left, with plus one bilateral effusion. The left knee examination was noted to show moderate tenderness about the medial aspect and over the medial joint line. The left foot examination revealed mild swelling over the arch and heel of the left foot, tenderness over the plantar fascia, first metatarsophalangeal joint tenderness, and painful motion of the first toe. Inspection of the cervical spine was noted to show tenderness of the cervical and paraspinal muscles and the spinous process, with pump handle test positive, and range of motion (ROM) decreased and painful on lateral motion. The treatment plan was noted to include requests for authorization for a right shoulder open cuff repair, a surgical assistant, post-operative physical therapy, a right knee and left shoulder MRI, and medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder open cuff repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 - 211, table 9 - 6.

**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:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 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. The physical exam from 3/6/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. The MRI from 8/21/13 shows no sign of rotator cuff tear. Based on the lack of surgical lesion and failure to meet the guidelines set forth above, the request is not medically necessary.

**Associated surgical services: Assistant surgeon: Upheld**

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

**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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Post-operative physical therapy for the right shoulder, three times weekly for four weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.