

<b>Case Number:</b>	CM15-0075538		
<b>Date Assigned:</b>	04/27/2015	<b>Date of Injury:</b>	01/11/2014
<b>Decision Date:</b>	06/29/2015	<b>UR Denial Date:</b>	04/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2015

### 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: Illinois, California, Texas  
 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 51-year-old female who sustained an industrial injury on 1/11/14. Injury occurred when she was leaving work and fell down four stairs. Past surgical history was positive for right knee arthroscopic partial medial meniscectomy on 7/1/14 and left knee arthroscopic partial medial meniscectomy on 12/2/14. The 3/25/14 left shoulder MRI impression documented moderately severe supraspinatus tendinosis with a deep bursal surface partial tear versus through and through perforation. There was reactive bursitis, moderate acromioclavicular arthrosis, mild capsulitis, and degenerative tears of the biceps anchor without detachment, subluxation, dislocation or rupture. The 3/16/15 orthopedic report cited complaints of low back, bilateral knee, and right shoulder pain. She reported that she was in bed all weekend due to pain. Physical exam documented antalgic gait with a cane, painful lumbar range of motion, generalized knee tenderness, and left knee clicking. Right shoulder exam documented pain with range of motion. Imaging was reported positive for right shoulder rotator cuff repair. The treatment plan recommended right shoulder operative arthroscopy with rotator cuff repair and subacromial decompression, possible arthrotomy, and biceps tenodesis vs. release of the right shoulder. Authorization was also requested for pre-operative physical and labs (chemistry panel, complete blood count, prothrombin time blood test, partial thromboplastin time blood test, urinalysis, chest x-ray and electrocardiogram); post-operative physical therapy 2 times a week for 6 weeks and post-operative shoulder immobilizer and cold therapy unit for the right shoulder. The 4/13/15 utilization review non-certified the right shoulder operative arthroscopy with rotator cuff repair and subacromial decompression, possible arthrotomy, and biceps tenodesis vs. release of the

right shoulder, and associated surgical requests, as there was no significant rotator cuff pathology on imaging, incomplete clinical exam, and no evidence of conservative treatment including physical therapy and corticosteroid injection.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right Shoulder Operative Arthroscopy with Rotator Cuff Repair and Subacromial Decompression, Possible Arthrotomy, and Biceps Tenodesis vs. Release of the Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for rotator cuff repair; Surgery for impingement syndrome.

**Decision rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines for rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment, plus painful arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, rotator cuff or anterior acromial tenderness, and positive impingement sign with a positive diagnostic injection test. Criteria include imaging evidence of a rotator cuff deficit. Guideline criteria have not been met. This injured worker presents with right shoulder pain. There is imaging evidence of a partial thickness rotator cuff tear with moderate acromioclavicular arthrosis and a degenerative biceps tendon tear. However, clinical exam evidence was limited to restricted and painful range of motion. Detailed evidence of 3 to 6 months a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no evidence of a positive diagnostic injection test. Therefore, the request is not medically necessary.

**Pre-Operative Physical and Labs: Chem panel, CBC, PT/PTT, urinalysis, Chest X-Ray and Electrocardiogram:** 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.

**Post-Operative Physical Therapy (12-sessions, 2 times a week for 6 weeks):** 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.

**Post-Operative Shoulder Immobilizer and Cold Therapy Unit for the Right Shoulder:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous flow cryotherapy; Immobilization.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.