

<b>Case Number:</b>	CM14-0143539		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	06/01/2004
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	08/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient has a date of injury of June 1, 2004. The patient has chronic shoulder pain. The patient had right shoulder subacromial decompressive surgery and labral repair with rotator cuff repair in May 2005. In February 2008 the patient had revision rotator cuff repair labral debridement and subacromial decompression with distal clavicle resection. In December 2009 the patient had revision right shoulder arthroscopy with subacromial decompression distal clavicle excision and SLAP (Superior labral anteroposterior) repair. MR arthrogram in June 2013 showed non-retracted tear of the supraspinatus and interested as tendons. On physical examination the patient has shoulder flexion 240 and abduction to 160. The patient reports continued shoulder pain with motion. The patient also reports clicking in the right shoulder. At issue is whether revision shoulder surgery is medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic right shoulder subacromial decompression, distal clavicle resection and rotator cuff debridement and repair:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG shoulder pain chapter

**Decision rationale:** This patient does not meet establish criteria for revision right shoulder surgery. The medical records do not document activity limitation for more than 4 months with failure to increase range of motion after physical therapy. There has not been an adequate trial of conservative measures to include recent cortisone injections. Injection should be carried out at least 3-6 months before considering surgery. This patient had 3 previous rotator cuff surgeries for the right shoulder. The patient is having ongoing shoulder pain. Second opinion indicates that the patient may have a problem with the biceps tendon. Most recent imaging studies were conducted 4 months prior to the last surgery. There are no recent imaging studies. Examination does not show severe loss of motion. Physical examination imaging studies do not support the need for revision rotator cuff surgery at this time. Does not documentation of an adequate trial and failure of conservative measures and there no red flag indicators for shoulder surgery at this time. Criteria for revision shoulder surgery not met.

**Pre-operative 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.

**Supervised post-operative rehabilitative therapy three (3) times a week for four (4) 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.

**Home continuous passive motion (CPM) device for forty-five (45) days:** 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.

**Surgi-stim unit for ninety (90) days, then purchase:** 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.

**█ 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.