

<b>Case Number:</b>	CM14-0157770		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	08/20/2013
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 California. 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:

This 46-year-old female warehouse lead picker sustained an industrial injury on 8/20/13. Injury occurred relative to the repetitive motion and heavy lifting. Records indicated that the patient had been treated for neck and bilateral shoulder, elbow, and wrist complaints. Conservative treatment included activity modification, elbow straps, corticosteroid injection to the bilateral wrists, anti-inflammatory medications, and physical therapy for her bilateral arm symptoms. The 5/6/14 right shoulder MRI findings documented mild supraspinatus tendonitis without evidence for a tear, and no SLAP lesions. The glenohumeral and acromioclavicular joints were well aligned, and the biceps tendon was appropriately located. The 5/14/14 right shoulder x-ray impression documented minimal type II acromion process and a small inferior osteophyte from the distal clavicle. The acromioclavicular joint was poorly visualized but may be mildly arthritic. The 7/30/14 treating physician report cited right shoulder pain. There was limited range of motion with pain on abduction, tenderness over the rotator cuff, and positive impingement signs. The 9/3/14 treating physician report cited complaints of right shoulder pain. Physical exam documented point tenderness over the coracoacromial arch with positive empty can test. Authorization was requested for right shoulder diagnostic arthroscopy with possible rotator cuff repair, distal clavicle excision, subacromial decompression, and biceps tenotomy versus labral repair. The 9/16/14 utilization review denied the request for right shoulder surgery as there was no clear evidence of a surgical lesion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Biceps Tenotomy vs. Labral Repair: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**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. The Official Disability Guidelines recommend surgery for SLAP lesions after 3 months of conservative treatment for Type II or IV lesions, when history and physical exam and imaging indicate pathology. Guideline criteria have not been met. There is no clear clinical and imaging evidence of a SLAP lesion. Evidence of 3 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

**Subacromial Decompression: Upheld**

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

**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 impingement syndrome

**Decision rationale:** The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. There is no documentation of a positive diagnostic injection or corticosteroid injection to the right shoulder. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no clear imaging evidence of impingement. Therefore, this request is not medically necessary.

**Distal Clavicle Excision: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. There is no documentation of a positive diagnostic injection or corticosteroid injection to the right shoulder. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no clear imaging evidence of impingement. Therefore, this request is not medically necessary.

**Diagnostic Right Shoulder Arthroscopy with possible Rotator Cuff Repair:** Upheld

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

**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

**Decision rationale:** The California MTUS guidelines provide general recommendations for rotator cuff repair. For rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for three months. The Official Disability Guidelines criteria for rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment. Surgical indications include pain with active arc motion 90-130 degrees, pain at night, weak or absent abduction, rotator cuff or anterior acromial tenderness, positive impingement sign, temporary relief of pain with anesthetic injection, and imaging evidence of rotator cuff deficit. Guideline criteria have not been met. There is no documentation of temporary pain relief with an anesthetic injection. There is no clear imaging evidence of rotator cuff deficit. Evidence of 3 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, directed to the right shoulder, and failure has not been submitted. Therefore, this request is not medically necessary.