

<b>Case Number:</b>	CM14-0158844		
<b>Date Assigned:</b>	10/02/2014	<b>Date of Injury:</b>	11/20/2013
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	09/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 37-year-old female sustained an industrial injury on 11/20/13 relative to lifting. The 3/29/14 right shoulder MRI impression documented T2 prolongation with an otherwise intact supraspinatus tendon compatible with tendinitis. Subtle intrasubstance delamination tearing could not be excluded. There was a Type 1 acromion with a flat undersurface against the rotator cuff. There was moderate fluid seen in the subacromial/subdeltoid space consistent with subacromial bursitis. Conservative treatment included physical therapy, activity modification, home exercise program, anti-inflammatory medication, and pain medication. A right shoulder subacromial corticosteroid injection was provided on 8/13/14. The 8/27/14 treating physician report cited on-going right shoulder pain since date of injury with one week of some pain relief following the recent corticosteroid injection. Pain was rated 6/10 at rest and 10/10 with activity. She was unable to raise the right arm much above shoulder level in any direction and cannot sleep at night. Physical exam documented lack for right shoulder muscle definition compared to the left shoulder suggestive of favoring and muscle atrophy. Range of motion testing demonstrated abduction 105, adduction 20, flexion 110, extension 20, external rotation 20, and internal rotation 20 degrees. There were positive Neer and Hawkins tests for anterior impingement. The right shoulder was stable to clinical testing for anterior, inferior and posterior instability. There was tenderness over the rotator cuff, acromioclavicular joint, and trapezius muscle. There was normal upper extremity strength and sensation. The diagnosis was chronic sprain/strain of the right shoulder with impingement of the rotator cuff and possible tear. There was imaging evidence of a possible partial tear and impingement. The patient had failed corticosteroid injection. Authorization was requested for right shoulder open subacromial decompression and rotator cuff repair. The 9/22/14 utilization review modified the request for

right shoulder subacromial decompression and rotator cuff repair to right shoulder subacromial decompression.

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

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

**Rotator cuff repair of right shoulder:** Overturned

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

**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 and impingement syndrome. For rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for three months. The preferred procedure is arthroscopic decompression. The Official Disability Guidelines provide specific criteria for rotator cuff repair of partial thickness tears that 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 been met. Subjective and clinical exam findings are consistent with imaging evidence of impingement. There is plausible clinical evidence of a rotator cuff tear which is often associated with impingement and confirmed at the time of surgery. Reasonable non operative treatment appears to have been tried and failed. Therefore the request including at the level of the rotator cuff is medically necessary.