

<b>Case Number:</b>	CM14-0162599		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	01/02/2012
<b>Decision Date:</b>	11/26/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2014

### 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 53 year old male claimant with an industrial injury dated 01/02/12. The patient is status post a left shoulder arthroscopy, decompression, Mumford as of 08/13/12. X-ray of the left shoulder dated 05/16/13 reveals a wide AC interval from resection, some ossicle retained in interval with no sign of glenohumeral changes. MRI of the left shoulder dated 06/10/13 reveals high-grade partial vs. full thickness tearing of the supraspinatus tendon and at least 6 mm AP with retraction to the top of the humeral head. X-ray of the right knee dated 04/09/14 demonstrates no evidence of fracture and minimal tibial spine spurring. Exam note 08/29/14 states the patient returns with left shoulder pain. There was no muscle atrophy. Conservative treatments have included medication, physical therapy, and cortisone injections. Diagnosis is noted as a partial tear of the left rotator cuff, lower right leg pain, and shoulder impingement syndrome along with a strain/sprain. Treatment includes a left shoulder arthroscopy, and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Left Shoulder Scope, Lysis of Adhesions Revision Decomo: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment " Integrated Treatment Disability Duration Guidelines: Shoulder chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation (ODG) Shoulder, Acromioplasty

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 8/29/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 8/29/14 does not demonstrate evidence satisfying the above criteria. Therefore the request is not medically necessary and appropriate.

**Left Shoulder Revision Mumford:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment " Integrated Treatment Disability Duration Guidelines: Shoulder chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation (ODG) Partial Claviclectomy

**Decision rationale:** Based upon the CA MTUS Shoulder Chapter. Pages 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for posttraumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case the exam note from 8/29/14 and the imaging findings from 6/10/13 do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the request is not medically necessary and appropriate.

**Left Shoulder Possible RC Repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment " Integrated Treatment Disability Duration Guidelines: Shoulder chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation (ODG) Shoulder section, Surgery for rotator cuff repair

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 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. In this case the submitted notes from 8/29/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 8/29/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the request is not medically necessary and appropriate.