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| <b>Case Number:</b>   | CM14-0179338 |                              |            |
| <b>Date Assigned:</b> | 11/12/2014   | <b>Date of Injury:</b>       | 07/03/2014 |
| <b>Decision Date:</b> | 12/26/2014   | <b>UR Denial Date:</b>       | 09/29/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/28/2014 |

### 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 is a 56 year old male with a 7/3/14 injury date. He fell directly onto his left shoulder. A left shoulder MRI report on 8/21/14 revealed a full-thickness tear of the subscapularis tendon with 3 cm of retraction and a superior labrum anterior posterior (SLAP) tear. Left shoulder x-rays on 7/3/14 showed acromioclavicular (AC) joint arthrosis. In an 8/13/14 note, the patient complained of worsening left shoulder pain and weakness. Objective findings included left shoulder anterior tenderness, abduction to 65 degrees forward flexion to 70 degrees, positive impingement signs, and weakness with internal and external rotation. In a 9/17/14 note, the patient could only abduct and forward flex to about 45 degrees. A 7/3/14 note documented no tenderness over the AC joint. Diagnostic impression: left shoulder subscapularis tendon tear, SLAP tear. Treatment to date: medications including NSAIDS, physical therapy (6 sessions). A UR decision on 9/29/14 denied the requests for left shoulder arthroscopic subacromial decompression, distal clavicle resection, evaluation of the rotator cuff, manipulation under anesthesia, and possible need to open for subscapularis repair because the official MRI report was not submitted for review and a comprehensive left shoulder physical exam was not documented.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic subacromial decompression:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Surgery for impingement syndrome.

**Decision rationale:** CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. In this case, subacromial decompression is an important adjuvant procedure in conjunction with the treatment of the rotator cuff tear. Given the certification of the subscapularis repair, a subacromial decompression is appropriate. Therefore, the request for left shoulder arthroscopic subacromial decompression is medically necessary.

**Distal clavicle resection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Partial claviclectomy (Mumford procedure).

**Decision rationale:** CA MTUS and ODG support partial claviclectomy (including Mumford procedure) with imaging evidence of significant AC (acromioclavicular) joint degeneration along with physical findings (including focal tenderness at the AC joint, cross body adduction test, active compression test, and pain reproduced at the AC joint with the arm in maximal internal rotation may be the most sensitive tests), and pain relief obtained with an injection of anesthetic for diagnostic purposes. Non-surgical modalities includes at least 6 weeks of care directed towards symptom relief prior to surgery including anti-inflammatories and analgesics, local modalities such as moist heat, ice, or ultrasound. However, although the MRI showed signs of AC joint arthrosis, there was no tenderness to palpation over the AC joint on exam and no documentation of a positive cross-body adduction test. In addition, there was no previous AC joint injection documented. Therefore, the request for distal clavicle resection is not medically necessary.

**Evaluation of the rotator cuff:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Rotator cuff repair.

**Decision rationale:** CA MTUS states that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation; conservative treatment of full thickness rotator cuff tears has results similar to surgical treatment, but without the surgical risks, and further indicate that surgical outcomes are not as favorable in older patients with degenerative changes about the rotator cuff. In addition, ODG criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. In this case, the patient has an acute full-thickness tear of the subscapularis tendon. In the setting of an acute tear, ODG states that criteria for prior conservative treatment do not apply. On exam, the patient has significant limitations in left shoulder function as evidenced by weakness on internal and external rotation and severely limited range of motion. The left shoulder MRI confirms the presence of a full-thickness tear with 3 cm of retraction. Arthroscopic or open repair of the subscapularis tendon is recommended. Therefore, the request for evaluation of the rotator cuff is medically necessary.

**Manipulation under anesthesia:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Manipulation under anesthesia (MUA).

**Decision rationale:** CA MTUS and ODG criteria for manipulation under anesthesia include adhesive capsulitis refractory to conservative therapy lasting at least 3-6 months where abduction remains less than 90. However, although there was reduced left shoulder range of motion, there was not a clear differentiation between active versus passive range of motion on physical exam. Thus, the diagnosis of adhesive capsulitis could not be established. Therefore, the request for manipulation under anesthesia is not medically necessary.

**Possible need to open for subscapularis repair:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Rotator cuff repair.

**Decision rationale:** CA MTUS states that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation; conservative treatment of full thickness rotator cuff tears has results similar to surgical treatment, but without the surgical risks, and further indicate that surgical outcomes are not as favorable in older patients with degenerative changes about the rotator cuff. In addition, ODG criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. In this case, the patient

has an acute full-thickness tear of the subscapularis tendon. In the setting of an acute tear, ODG states that criteria for prior conservative treatment do not apply. On exam, the patient has significant limitations in left shoulder function as evidenced by weakness on internal and external rotation and severely limited range of motion. The left shoulder MRI confirms the presence of a full-thickness tear with 3 cm of retraction. Arthroscopic or open repair of the subscapularis tendon is recommended. Therefore, the request for possible need to open for subscapularis repair is medically necessary.