

<b>Case Number:</b>	CM14-0040484		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	12/04/2012
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	03/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 47 year old male, who sustained an industrial injury on December 4, 2012, climbing a ladder carrying construction material, pulling the shoulder. The injured worker has reported pain in the right shoulder. The diagnoses have included right shoulder partial rotator cuff tendon tear involving the supraspinatus and infraspinatus tendons, potential partial biceps tear, humeral head degenerative cyst and potential old Hill-Sachs lesion, possible SLAP lesion, cervical degenerative disc disease with poor posture, and probable left shoulder partial rotator cuff tear. Treatment to date has included cortisone injection, medications, and physical therapy. Currently, the injured worker complains of right shoulder pain. The Orthopedic Physician's visit dated February 28, 2014, noted the injured worker improved after a cortisone injection. Physical examination noted improved range of motion of the shoulder with distinct crepitus and positive impingement signs one and two, and distinct weakness in the right shoulder. On March 31, 2014, Utilization Review modified a request for right shoulder arthroscopy, labral rotator cuff repair and subacromial decompression, plus or minus distal clavicle resection, noting the MTUS guidelines supported the requested right shoulder arthroscopy, labral repair, and subacromial decompression as medically necessary, and the requested rotator cuff repair plus or minus distal clavicle resection not medically necessary as there was no evidence in the provided documentation to support guideline requirements of medical necessity. The MTUS, ACOEM Guidelines, Shoulder Complaints, was cited. On April 7, 2014, the injured worker submitted an application for IMR for review of right shoulder arthroscopy, labral rotator cuff repair and subacromial decompression, plus or minus distal clavicle resection.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Plus or minus distal clavicle resection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Section: Shoulder, Topic: Partial claviclectomy

**Decision rationale:** Per ODG guidelines, resection of the lateral clavicle is indicated after 6 weeks of conservative care for arthritis of the acromioclavicular joint in the presence of subjective clinical findings of pain at the acromioclavicular joint, aggravation of pain with shoulder motion or carrying weight plus objective clinical findings of tenderness over the acromioclavicular joint plus imaging clinical findings of posttraumatic changes of acromioclavicular joint or severe degenerative joint disease of acromioclavicular joint or complete or incomplete separation of acromioclavicular joint and bone scan is positive for acromioclavicular joint separation. The MRI scan does not show severe acromioclavicular arthritis. The documentation submitted does not indicate the above indications for lateral claviclectomy and as such, the medical necessity of the request is not substantiated.

**Right shoulder arthroscopy, labral rotator cuff repair, subacrominal decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211.

**Decision rationale:** California MTUS guidelines indicate surgical considerations for activity limitation for more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit, and both the short and long term, from surgical repair. Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of the arm elevation or rotation. For partial-thickness rotator cuff tears and small full-thickness rotator cuff tears surgery is reserved for cases failing conservative therapy for 3 months. The preferred procedure is arthroscopic decompression. Surgery is not indicated for patients with mild symptoms or those whose activities are not limited. The documentation provided indicates a partial thickness tear and not a full-thickness rotator cuff tear. Therefore surgical repair of the rotator cuff is not indicated per guidelines. As such, the request for a rotator cuff repair is not supported and the medical necessity is not substantiated.

