

<b>Case Number:</b>	CM15-0103745		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	01/02/2015
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	05/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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: Arizona

Certification(s)/Specialty: 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 34 year old female, who sustained an industrial injury on 1/2/15. She reported initial complaints of left shoulder injury. The injured worker was diagnosed as having rotator cuff tendinosis; Type II superior labral anterior posterior tear. Treatment to date has included physical therapy; medications. Diagnostics included X-rays left shoulder (1/5/15); MRI left shoulder (3/9/15). Currently, the PR-2 notes dated 4/27/15 are the "Initial Orthopedic Consultation" notes. The documentation indicated the injured worker complains of a left shoulder injury and has had 6 sessions of physical therapy without improvement. She has had a left shoulder MRI. This report was submitted with the medical as follows. A left shoulder MRI dated 3/9/15 documents "no evidence for a full-thickness or retracted tear involving the rotator cuff. Partial tear-tendinosis involving the supraspinatus tendon predominately the bursal-sided fibers with minimal fatty atrophy of the supraspinatus musculature; laterally downsloping acromion which narrows the acromiohumeral interval and can predispose to the clinical findings of impingement; mild to moderate subacromial/subdeltoid bursal fluid/bursitis; signal changes notes along the anteroinferior labrum which were suggestive of a tear." The provider documents he reviewed the MRI results and notes there is significant irregularity or detachment of the anterior-superior labrum suggestive of a SLAP tear Type 2, although he did not appreciate any rotator cuff tear on the images. In additional, she has been treated with anti-inflammatories taking Ibuprofen 800mg three times a day. Her pain level is 7/10 and notes that rest alleviates the pain. Lifting, internal rotation of the shoulder and forward elevation makes the pain worse. On physical examination of the left shoulder, there is forward flexion 170 degrees. There is positive

apprehension and relocation test. There is positive Hawkin's impingement sign and negative Neer's impingement with a positive O'Brien's test. She has slight weakness with rotator cuff testing with thumbs down on abduction. There is normal external rotation at 100 degrees, normal external rotation at the side at 70 degrees and internal rotation notes at 70 degrees. Her distal neurological and vascular exam was normal. The provider notes a diagnosis of "rotator cuff tendinosis" and likely a Type 2 SLAP tear. His treatment plan includes a left shoulder cortisone injection which the injured worker refused. The provider has requested authorization of an Arthroscopic Subacromial Decompression left shoulder.

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

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

**Arthroscopic Subacromial Decompression left shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

**Decision rationale:** Invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injection. Based on the above, if pain (due to impingement) significantly limits activities, then the next recommended step is a subacromial injection of local anesthetic and a corticosteroid preparation. The arthroscopic subacromial decompression of the left shoulder is not found to be medically necessary as the patient has not yet had (and has refused) steroid injection. The request is not medically necessary.