

<b>Case Number:</b>	CM15-0145268		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	03/02/2015
<b>Decision Date:</b>	09/04/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: Illinois, California, Texas  
 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:

This injured worker was a 60-year-old male who sustained an industrial injury on 3/2/15. Injury occurred when he went to reach for a falling object while working as an operating room nurse, and felt a severe pain in his shoulder. Initial conservative treatment included medications and activity modification. The 4/10/15 right shoulder MRI impression documented hypertrophic acromioclavicular (AC) joint involving the clavicular component which could cause improvement. There was a 50% undersurface partial thickness tear of the supraspinatus tendon, and partial thickness tear of the subscapularis tendon. There was a tear of the long head of the biceps tendon with detachment from the superior labral anchor which appeared to have abnormal morphology and findings suggestive of a partial thickness tear of the superior posterior glenoid labrum. There was small joint effusion. The 4/14/15 treating physician report cited right shoulder pain with decreased range of motion and weakness. Pain woke him at night. Physical exam documented 4/5 weakness in forward elevation and external rotation, positive AC joint tenderness, and active range of motion 90/45/hip. X-rays were obtained and showed sclerosis of the acromion and greater tuberosity consistent with chronic rotator cuff impingement. A formal course of physical therapy was recommended. The injured worker declined a corticosteroid injection. The 5/14/15 treating physician report cited increased right shoulder pain with physical therapy. Pain woke him at night and affected activities of daily living. He had been off work and was anxious to return to work. There was a slight increase in range of motion with physical therapy. Imaging showed a partial thickness rotator cuff tear and long head biceps tendon tear. Additional therapy was recommended. The 6/12/15 progress report cited significant right

shoulder pain interfering with activities of daily living and becoming intolerable. He had failed physical therapy and had tried to schedule an appointment for an injection but the wait was too long. Physical exam was reported positive for AC joint tenderness. The injured worker did not wish to live with his current condition any longer and decided on surgical option. Authorization was requested for right shoulder arthroscopic surgery for rotator cuff repair. The 6/14/15 physical therapy progress report cited global right shoulder tenderness with active range of motion of flexion 135 degrees and abduction 100 degrees. There was 4+/5 flexion, abduction, and external rotation weakness. The 6/30/15 utilization review non-certified the request for right shoulder arthroscopic rotator cuff repair as there were limited clinical exam findings documented to support the rotator cuff as the source of pain, and no detailed evidence of conservative treatment attempted and response. The 7/15/15 injured worker appeal letter stated that he had intense pain, severe range of motion limitations, inability to lift, sleep disturbance, and multiple restrictions of activities of daily living. He had reported this to the surgeon and physical therapist. He also had a biceps tendon rupture. He reported that he occasionally dropped things. He wanted to get back to work. He appealed the denial of surgery.

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

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

**Arthroscopic rotator cuff repair to the right shoulder:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**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 impingement syndrome; Surgery for rotator cuff repair.

**Decision rationale:** The California MTUS guidelines provide a general recommendation for impingement surgery and rotator cuff surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome and partial thickness rotator cuff repairs that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement or rotator cuff deficiency. Guideline criteria have been essentially. This injured worker presents with persistent right shoulder pain that interferes with activities of daily living and precludes return to work. Clinical exam findings are consistent with imaging evidence of impingement, partial thickness rotator cuff tears, biceps tendon tear with detachment, and possible labral tear. Detailed evidence of 3 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.