

<b>Case Number:</b>	CM15-0169522		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	10/29/2004
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	07/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2015

### 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: California, Oregon, Washington  
 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 57 year old female who sustained an industrial injury on 10-29-04. The assessment is left shoulder complete rotator cuff tear, left shoulder labral tear, left shoulder status post surgery, and depression. Previous treatment includes rotator cuff repair surgery-2005. In an initial complex orthopedic evaluation dated 7-14-15, the physician reports the injured worker was treated conservatively and then underwent a rotator cuff repair surgery. She has moderate to severe pain in the left shoulder that is constant. She is unable to do any of her activities of daily living secondary to pain and weakness in the shoulder. She notes she is unable to lift her arm above waist level and cannot carry anything heavy. She has a past history of depression related to her disability and pain and of gastric bypass surgery. Current medications are Gabapentin, Norco, Prilosec, Effexor and compounding creams. MRI of the left shoulder on 5-2-13 revealed a full thickness rotator cuff tear and labral tear. Exam of the left shoulder reveals Neer's test, Hawkin's test and drop arm test, are all positive. There is crepitus and acromioclavicular joint tenderness. Resisted abduction strength is 4 out of 5 as is resisted external rotation. Left shoulder range of motion in degrees is abduction 90, forward flexion 90, internal rotation 20, and external rotation is 20. Work status is temporary total disability. A request for authorization is dated 7-15-15. The requested treatment of arthroscopy, subacromial decompression of the acromioclavicular joint resection and rotator cuff repair- left shoulder, X-rays of the left shoulder and Psych consultation and treatment was not authorized on 7-31-15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopy, subacromial decompression AC joint resection and rotator cuff repair, left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Partial Claviclectomy & 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. 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 provided do not demonstrate 4 months of failure of activity modification. The physical exam does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is for non-certification for the requested procedure. 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. 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 notes do not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the determination is for non-certification. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post-traumatic 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 notes provided and the imaging findings do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore, the determination is for non-certification.

**Associated surgical services: X-rays of the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Partial Claviclectomy & acromioplasty.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical services: Psych consultation and treatment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Partial Claviclectomy & acromioplasty.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.