

<b>Case Number:</b>	CM15-0201066		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	06/20/2013
<b>Decision Date:</b>	11/30/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2015

### 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 52-year-old male who sustained an industrial injury on 6/20/13. Injury occurred while fighting a structure fire and pulling/advancing a fire hose. The 11/6/14 left shoulder MRI impression documented no rotator cuff tendon tear, retraction or muscle atrophy. The long head biceps tendon was seen within the bicipital groove. The long head biceps/superior labrum anchor was intact with no labral tear or paralabral cyst. There was thickening of the axillary pouch with reduced signal which could suggest capsular scarring or a sequelae of adhesive capsulitis. There were mild degenerative hypertrophic changes of the acromioclavicular (AC) joint reducing the outlet space for the supraspinatus tendon. Clinical correlation was recommended for signs of rotator cuff impingement. There was mild subacromial, subdeltoid, and subcoracoid bursitis. The 7/21/15 orthopedic report indicated that the injured worker was last seen 2 years ago, had improved symptoms, and returned to full duty. He currently presented with persistent left shoulder pain with sleeping and driving, and difficulty with swimming and lifting weights. He was taking tramadol and Relafen for chronic back pain. Physical exam documented tenderness over the posterolateral acromial corner, minimal AC joint tenderness, intact sensation, and forward flexion 180 degrees with mild Neer. There was moderate Hawkins and cross arm tests, and positive posterior pain with upright abduction external rotation. Lift-off was 5-/5 with moderate anterior ache. External rotation was 75 degrees with posterior pain on stretch. Imaging of the left shoulder showed intact cuff, normal proximal biceps, normal labrum, mild thickening inferior capsule (adhesive capsulitis), and AC joint degenerative changes. The diagnosis was left shoulder impingement, mild AC arthritis, rule-out SLAP tear, rule-out cervical radicular etiology. The treatment plan documented a discussion of operative and non-operative

treatments including therapy with NSAID use, injection therapy, and arthroscopy for potential SLAP tear. The 9/8/15 treating physician report cited persistent left shoulder pain. Symptoms were worse in the morning and during cold weather suggestive of mild degeneration/arthritis. Imaging suggested bursitis. The injured worker underwent left shoulder corticosteroid injection 2 weeks ago with temporary numbness. Left shoulder exam documented tenderness at the distal supraspinatus and posterior glenohumeral joint. Range of motion was full and pain free in forward flexion, abduction and adduction. External rotation was 90 degrees and painful. Internal rotation was 70 degrees with pain at the posterior shoulder. There was mild pain with supraspinatus testing. Impingement signs were not painful. There was no AC joint tenderness. The injured worker was continuing to work full duty without limitations or restrictions. He was taking multiple medications, including anti-inflammatory medication for his back which helped with his shoulder. The treatment plan recommended authorization for surgery per the orthopedic surgeon recommendations. Authorization was requested for outpatient left shoulder arthroscopic surgery with possible acromioplasty, acromioclavicular (AC) joint revision and or superior labrum anterior posterior (SLAP) tear repair. The 9/21/15 utilization review non-certified the request for outpatient arthroscopic surgery with possible acromioplasty, AC joint revision and/or SLAP tear repair as there was no clear objective clinical evidence of significant shoulder impairment that would require surgical intervention and no formal MRI report was present to evidence pathology that would benefit from the proposed surgery.

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

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

**Outpatient Arthroscopic Surgery with possible acromioplasty, acromioclavicular joint revision and/or Superior Labrum anterior posterior (SLAP) tear repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

**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 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. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. Guideline criteria have not been met. This injured worker presents with persistent left shoulder pain. He remains at full duty work without restriction, with functional difficulty noted in swimming and weight lifting. Clinical findings have been generally consistent with imaging evidence of AC joint degeneration with plausible impingement. There is

documentation of short term numbness following a shoulder injection. However, detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.