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| <b>Case Number:</b>   | CM15-0222828 |                              |            |
| <b>Date Assigned:</b> | 11/18/2015   | <b>Date of Injury:</b>       | 11/30/2009 |
| <b>Decision Date:</b> | 12/30/2015   | <b>UR Denial Date:</b>       | 10/20/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/12/2015 |

### 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 is a 47-year-old female who sustained an industrial injury on 11/30/09, relative to repetitive work duties as an optician manager. The 6/6/13 cervical spine MRI impression documented a 3.5 mm broad-based right disc protrusion at C4/5 resulting in very severe right foraminal stenosis, moderate central canal stenosis, and severe left foraminal stenosis. There was mild degenerative disc disease at C3/4, C5/6 and C6/7 characterized by small disc bulges and protrusions. Conservative treatment had included 24 visits of physical therapy, bracing, and steroid injections for the right elbow. The 7/7/15 orthopedic re-evaluation report indicated that the injured worker had completed 3/6 authorized physical therapy sessions without improvement. She was reporting increase difficulties, more pain, and difficulty sleeping. Physical exam documented full cervical range of motion and normal upper extremity neurologic exam. Right shoulder exam documented full range of motion with a markedly positive impingement test and multiple painful arcs. There was right elbow medial epicondyle tenderness and positive Finkelstein and Phalen's tests on the right wrist. The diagnosis included right upper extremity overuse syndrome and partial rotator cuff tear. She was placed on modified duty and was taking ibuprofen. Referral to a surgeon who performs arthroscopic shoulder surgery was recommended. The 7/23/15 physical therapy progress report indicated that the injured worker had continued intermittent activity dependent right shoulder and arm pain. She reported feeling better with a complete decrease in her symptoms. The physical therapist reported that there were still signs of complex regional pain syndrome with radicular type pain and cervical/cervicothoracic junction hypomobility. She responded well to a combination of manual therapy and therapeutic exercise to improve cervical spine mobility and postural

strength and stability. The 9/25/15 right shoulder MRI impression documented tendinosis and bursal surface fraying of the distal supraspinatus tendon and mild subacromial-subdeltoid bursitis. The 9/25/15 right elbow MRI documented partial tearing and scarring of the radial collateral ligament. The 9/29/15 upper extremity EMG/NCV impression documented mild right carpal tunnel syndrome. The 10/1/15 treating physician report cited continued bilateral elbow and right shoulder pain, arm weakness and numbness, and inability to use the arms in a normal fashion. She was not able to work. Physical exam documented right shoulder range of motion as flexion 135, extension 0, abduction 130, adduction 30 degrees, and internal/external rotation 70 degrees. There was tenderness over the acromioclavicular (AC) joint and a positive impingement sign. Bilateral elbow exam documented lateral tenderness, range of motion 0-120 degrees, and positive flexion test. Right wrist exam documented positive Phalen's, Tinel's, and Finkelstein tests. Grip strength was 20 pounds right and 50 pounds left. The diagnosis included right shoulder impingement with rotator cuff bursitis, tendonitis and possible tear, elbow tendonitis and epicondylitis, and right carpal tunnel syndrome and deQuervain's. Right shoulder and elbow MRIs had been performed but the reports were not available. Authorization was requested for an arthroscopic right shoulder, decompression and possible repair of rotator cuff, right AC excision. The 10/20/15 utilization review non-certified the request for an arthroscopic right shoulder, decompression and possible repair of rotator cuff, right AC excision as there was no detailed documentation relative to conservative treatment for the right shoulder, including injection, and there was very little evidence of pathology on imaging to support surgery without exhaustion of conservative treatment measures.

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

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

**Arthroscopic right shoulder, decompression and possible repair of rotator cuff, right AC excision:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome; Surgery for rotator cuff repair; Partial claviclectomy.

**Decision rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines provide more specific indications for impingement syndrome and rotator cuff repairs that include 3 to 6 months of conservative treatment, 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 for partial claviclectomy include subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint pathology. Guideline criteria have not been fully met. This injured worker presents with neck and right upper extremity pain and dysfunction precluding return to work. Clinical exam is generally consistent with right shoulder impingement syndrome but there is no x-ray or MRI evidence of AC joint pathology or impingement. There is no evidence of a full thickness rotator cuff tear. There is no documentation of a positive diagnostic injection test. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the shoulder and failure has not been submitted. There are multiple pathologies noted in the neck and right upper extremity with no clear clinical or imaging evidence to support shoulder surgery at this time. Therefore, this request is not medically necessary at this time.