

<b>Case Number:</b>	CM15-0047821		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	07/31/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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: California  
 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 40 year old male, who sustained an industrial injury on 07/31/2014. He reported injury to the right shoulder. The injured worker was diagnosed as having adhesive capsulitis of the right shoulder; superior labral anterior-posterior lesion of the right shoulder; and right shoulder impingement syndrome. Treatment to date has included medications and physical therapy. A progress report from the treating provider, dated 02/10/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of moderate to severe right shoulder pain; clicking, popping, and catching sensations in the right subacromial region; loss of active range of motion in the shoulder joint; and weakness. Objective findings included right shoulder tenderness at the anterolateral corner of the acromion; crepitance at the subacromial space; decreased range of motion; and positive impingement sign. The plan of treatment included surgical intervention. Request is being made for right shoulder arthroscopy posterior-superior labral repair procedure; and arthroscopic subacromial decompression and distal clavicle resection procedure.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopy posterior-superior labral repair procedure: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Partial Claviclectomy.

**Decision rationale:** 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. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. There is insufficient evidence from the exam note of 2/10/15 to warrant labral repair secondary to lack of documentation of conservative care or characterization of the type of labral tear. Therefore request is not medically necessary.

**Arthroscopic Subacromial decompression and distal clavicle resection procedure:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder section, Acromioplasty surgery.

**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. 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 from 2/10/15. Therefore the request is not medically necessary.