

<b>Case Number:</b>	CM14-0116309		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	04/13/2013
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant is a 55-year-old female who sustained an April 13, 2013, slip-and-fall injury while working as a nurse. A June 20, 2013, MRI scan of the left upper extremity showed a normal rotator cuff, biceps and glenoid labrum, as well as an unremarkable acromioclavicular joint. The claimant completed a short course of physical therapy immediately following the injury. The records also document that the claimant was treated with three steroid injections, following which limited range of motion at the end ranges persisted. Left shoulder manipulation under anesthesia was performed in August 2013. A December 30, 2013, MR arthrogram showed mild degenerative changes of the acromioclavicular joint, mild rotator cuff tendinosis and a tiny partial thickness infraspinatus tear involving the insertional fibers of the supraspinatus. The findings were noted to be consistent with a normal-appearing joint. The claimant presented on May 5, 2014, for a qualified medical examination. The notes from this encounter document complaints of significant shoulder pain, continued symptoms and treatment by an orthopedic specialist, who provided a diagnosis of frozen shoulder. Specifically, the claimant presented with continued complaints of significant pain on certain ranges of motion inside her shoulder. Physical examination showed active range of motion with forward flexion to 180 degrees, abduction to 180 degrees, internal rotation to 60 degrees and external rotation to 90 degrees. Neer test was positive, and significant pain with forward flexion greater than 130 degrees was reported. Neurovascular pathology was intact. Radiographs showed left shoulder type II/III acromion and significant acromioclavicular joint arthrosis. A May 20, 2014, office note stated that the claimant reported constant pain and pain with range of motion. Physical examination showed palpable tenderness over the rotator cuff foot print and biceps tendon, as well as mild tenderness over the acromioclavicular joint. The claimant lacked approximately 5 to 10 degrees of active range of motion in all directions with pain at end ranges. Weakness and pain with

thumbs down testing were documented. Speed's test was negative; Neer and Hawkin's tests were positive. Sensations appeared to be grossly intact. The claimant was diagnosed with left shoulder residual adhesive capsulitis, impingement and partial thickness rotator cuff tear with possible labral tear. On June 6, 2014, the claimant underwent left shoulder examination under anesthesia, arthroscopic subacromial decompression, left shoulder arthroscopic distal clavicle resection, and arthroscopic rotator cuff and glenohumeral debridement. Other than physical therapy immediately following the injury and the three shoulder injections prior to the left shoulder manipulation under anesthesia in August 2013, no other conservative treatment is documented. This request is for retrospective authorization of the June 6, 2014, left shoulder surgery.

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

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

#### **Retro Left Shoulder SAD, Distal Clavicle Resection, Rotator Cuff Debridement and Biceps Tenodesis, Date of Service 6/6/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online Chapter: Shoulder - Surgery - Acromioplasty - Ruptured Biceps Tendon

**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 chapter: Partial claviclectomy (Mumford procedure)

**Decision rationale:** Under ACOEM Guidelines criteria, operative intervention may be indicated following more than four months of activity limitation, when exercise therapy fails to increase strength and range of motion, and when there is clear clinical and imaging evidence that a lesion exists that has been shown to benefit short- and long-term through surgical correction. In the setting of a partial thickness rotator cuff tear, there should be documentation of a three- to six-month period of continuous conservative treatment prior to proceeding with surgical intervention. Prior to proceeding with partial claviclectomy (Mumford procedure), according to the Official Disability Guidelines, the records should document treatment with an injection of an anesthetic, and plain-film radiographs should show post-traumatic change of the acromioclavicular joint, severe degenerative joint disease of the acromioclavicular joint or separation of the acromioclavicular joint. In this case, the reviewed records do not reference a three- to six-month trial of conservative care. Imaging studies were referenced but not provided; however, the referenced studies were not noted to show evidence of shoulder impingement and/or biceps tendon tear. No significant recent functional deficit or restricted activities of daily living were referenced. Given the absence of correlating clinical findings and lack of conservative care as outlined under ACOEM Guidelines, the left shoulder subacromial decompression, distal clavicle resection, rotator cuff debridement and biceps tenodesis performed on 06/06/14 are not supported as medically necessary.