

<b>Case Number:</b>	CM14-0126960		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	09/21/2012
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	07/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/11/2014

### 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 Orthopaedic 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:

This 29-year-old male construction worker sustained an industrial injury on 9/21/12. Injury occurred while lifting two pieces of glass (weighing approximately 130-150 pounds) into an overhead position, with onset of right shoulder symptoms. The patient underwent right shoulder arthroscopy with extensive labral debridement and subacromial decompression on 10/18/13. The 2/18/14 physical therapy report cited completion of 21 post-op visits with continued weakness of the scapular stabilizers and supraspinatus. The DASH score was 56% with prior scores reported at 53% and 58%. Pain was grade 3 at best and grade 8 at worst with disrupted sleep. Range of motion testing documented flexion 165, abduction 155, and external rotation 90 degrees with internal rotation to T12. Strength was reported 5-/5, but for external rotation which was 4+/5. The therapist indicated the patient needed to increase the frequency of his home exercise program and decrease the external traumatic events. The 6/11/14 treating physician report cited continued right shoulder pain with no significant improvement post-operatively. Shoulder range of motion was reported 160/160 with mild crepitus especially with abduction and positive impingement signs with forward elevation. MR arthrogram showed no obvious rotator cuff tear, possible labral tear, and persistent impingement. A subacromial injection was performed. The patient had failed 6 months of post-operative conservative treatment including physical therapy and medications. The treatment plan recommended right shoulder arthroscopy with subacromial decompression and rotator cuff tear debridement. The 7/3/14 treating physician report documented no response to the cortisone/Marcaine injection performed on 6/11/14. Clinical exam findings and subjective complaints were unchanged. Surgery was again requested. The 7/11/14 utilization review denied the request for right shoulder surgery as there was no rotator cuff tear on imaging or direct visualization at the time of surgery. There was no evidence of acromioclavicular joint arthritis at the time of surgery. The 8/25/14 treating physician report

documented a reduction in range of motion 100/100 degrees with mild crepitus especially with abduction and positive impingement signs with forward elevation. Surgery was again recommended.

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

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

**Right Shoulder S/A, Rotator Cuff Tear (RCT) Debridement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty 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, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. There is no current imaging evidence of impingement, acromioclavicular joint arthritis, or rotator cuff tear. The subacromial diagnostic injection test was not positive. There is no documentation of current weakness, painful arc of motion, or tenderness consistent with guidelines. Therefore, this request is not medically necessary.