

<b>Case Number:</b>	CM14-0138194		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	09/19/2011
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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 Hand Surgery and is licensed to practice in Texas and Georgia. 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 injured worker is a 58-year-old male who reported an injury on 09/19/2011. The mechanism of injury was not submitted for clinical review. The diagnoses included cervical spine myofascitis with radiculitis, status post right shoulder arthroscopic surgery. The previous treatments included medication, physical therapy. The diagnostic testing included an MRI of the left and right shoulder, dated 05/13/2014. Within the clinical note dated 05/30/2014, it was reported the injured worker complained of right shoulder pain. The injured worker complained of left shoulder pain with moving and lifting and numbness. Upon the physical examination, the provider noted the injured worker had tenderness to the left greater than right shoulder. The provider noted the injured worker had left shoulder weakness 4/5. The provider indicated the injured worker had a positive hyperextension and Spurling's test, left greater than right. The MRI of the left shoulder revealed a large glenoid labral tear; the MRI of the right shoulder revealed a supraspinatus tendon full thickness tear involving a large portion of the supraspinatus tendon. The request submitted is for a subacromial decompression, and left shoulder arthroscopic rotator cuff and labral repair. However, a rationale was not submitted for clinical review. The Request for Authorization was submitted and dated on 07/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Subacromial decompression:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery indications for impingement syndrome

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

**Decision rationale:** The request for subacromial decompression is not medically necessary. The California MTUS/ACOEM guidelines note surgery for impingement syndrome is usually arthroscopic decompression. The procedure is not indicated for injured workers with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. There is clinical documentation indicating the injured worker attended physical therapy; however, no improvement was reported. The clinical documentation did not establish the failure of injection therapy. The request submitted failed to provide the left or right shoulder as a surgical site. Given these reasons, the requested surgical procedure is not indicated at this time. Therefore, the request is not medically necessary for a subacromial decompression.

**Left shoulder arthroscopic rotator cuff and labral repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff repair

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for SLAP lesions

**Decision rationale:** The request for left shoulder arthroscopic rotator cuff and labral repair is not medically necessary. The California MTUS/ACOEM guidelines note rotator cuff repair is indicated for significant tears that impair activities by causing weakness of the arm elevation or rotation, particularly acutely in younger workers. Rotator cuff tears are frequently partial thickness or small full thickness tears. For partial thickness rotator cuff tears and small thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for 3 months. The preferred procedure is usually arthroscopic decompression which involves debridement of the inflamed tissues, burning of the anterior acromion, lysis, and sometimes removal of the coracoacromial ligament and possibly removal of the outer clavicle. Surgery is not indicated for injured workers with mild symptoms or whose activities are not limited. In addition, the Official Disability Guidelines note recommendation for SLAP lesions for type 4 lesions if more than 50% of the tendon is involved. Surgery indications include failure of conservative treatment after 3 months. Type 2 lesion fraying and derangement of superior labrum, normal biceps, and no detachment. Type 4 more than 50% of the tendon is involved, vertical tear, bucket hand tear of the superior labrum which extends into the biceps. Generally, type 1 and 2 lesions do not need any treatment or are debrided. History and physical examinations and imaging indicate pathology. Definitive diagnosis of a SLAP lesion is diagnostic arthroscopy. Under the age of 50, otherwise considered bicep tenodesis.

Documentation submitted did not indicate the injured worker had tried and failed on conservative therapy for at least 3 months. There is no clinical indication the injured worker had activity limitations. Therefore, the request is not medically necessary.