

<b>Case Number:</b>	CM15-0077336		
<b>Date Assigned:</b>	04/28/2015	<b>Date of Injury:</b>	08/21/2014
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2015

### 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: Minnesota, Florida  
 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 41-year-old male with a date of injury of August 21, 2014. The body part injured is the left shoulder. MRI scan from November 4, 2014 showed tendinosis with no rotator cuff tear, possible bicipital tenosynovitis and mild acromioclavicular degenerative change. No other abnormalities were noted. An x-ray showed a type I acromion. There was no evidence of acromioclavicular arthritis. The guidelines necessitated 3-6 months of non-operative treatment with physical therapy and corticosteroid injections was not documented. A review of the medical records indicates that 24 physical therapy was requested on 2/11/2015 but physical therapy notes have not submitted. The progress note dated 3/13/2015 indicates that physical therapy was unsuccessful. The injured worker was complaining of increased symptoms of pain and numbness in the left upper extremity. The numbness involved all fingers of the left hand but was worse in the fourth and fifth fingers. The diagnostic workup does not include a workup for cervical radiculopathy. Utilization review noncertified a request for arthroscopy of the left shoulder with subacromial decompression and rotator cuff repair and possible labral repair on 3/19/2015. California MTUS guidelines were cited. This has been appealed to an independent medical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy for rotator cuff and labral tear repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 212 - 213.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

**Decision rationale:** California MTUS guidelines indicate surgical considerations for activity limitation for more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. The surgery for impingement syndrome is usually arthroscopic decompression. The procedure is not indicated for patients with mild symptoms or those with no activity limitations. Conservative care including cortisone injections can be carried out for at least 3-6 months before considering surgery. 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears is recommended. The documentation submitted does not include evidence of a trial/failure of a comprehensive non-operative treatment program for 3-6 months. The request as stated is for a rotator cuff repair and labral tear repair but the MRI scan does not show any evidence of a rotator cuff tear or labral tear. There is also a question of cervical radiculopathy and diagnostic lidocaine injections to distinguish pain sources in the shoulder area, for example impingement, have not been documented. The x-rays show a type I acromion and the MRI does not show a rotator cuff tear or labral tear. As such, the evidence-based guidelines do not recommend the requested surgical procedure of arthroscopy with rotator cuff repair and labral repair and the medical necessity of the request has not been substantiated. Therefore, the requested medical treatment is not medically necessary.