

<b>Case Number:</b>	CM13-0026754		
<b>Date Assigned:</b>	03/14/2014	<b>Date of Injury:</b>	11/30/2012
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	09/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2013

### 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 Texas. 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 patient is a 35-year-old male who reported an injury on 11/30/2012. The injury was noted to have occurred while he was pushing a file cabinet to another desk. The patient is diagnosed with chronic cervical, dorsal and lumbar spine strain, left shoulder strain/impingement/labral tear, and left elbow strain. An MRI of the left shoulder, performed on 12/27/2012, revealed an intermediate grade intrasubstance tear of the more anterior fibers of the supraspinatus tendon with concomitant mild to moderate supraspinatus tendonitis, no impingement, and no labral tear. A 07/08/2013 progress report indicates that the patient had a positive impingement sign of the left shoulder and was given a subacromial injection which relieved the patient's pain by 100% at 2 minutes. A recommendation was made to continue with physical therapy. A follow-up visit dated 07/22/2013 indicated that the patient received 2 weeks of relief for all of his left upper extremity symptoms from the previous subacromial injection. It was noted that this confirmed the diagnosis of left shoulder impingement and a recommendation was made for arthroscopic subacromial decompression. The patient saw his treating physician on 01/06/2014 with symptoms of cervical spine, thoracic spine, and lumbar spine pain. His physical examination revealed a positive impingement sign on the left shoulder, normal motor strength at 5/5 in all planes, slightly decreased active range of motion in flexion to 150 degrees and abduction to 140 degrees and internal rotation to 80 degrees. The patient was noted to have no tenderness to palpation of the left shoulder. It was noted that after re-examination, his treating physician felt that he had achieved maximum benefit from the treatment that has been provided to him and his condition with regard to his entire spine and left shoulder can be considered to have reached a permanent and stationary status and a level of maximum medical improvement. His future medical care recommendation indicated that the patient should have access to arthroscopy and subacromial decompression of his left shoulder.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **LEFT SHOULDER ARTHROSCOPY WITH SUBACROMIAL DECOMPRESSION**

**29826:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM OCCUPATIONAL MEDICINE PRACTICE GUIDELINES, 2ND EDITION, 2008, SHOULDER COMPLAINTS, PAGES 560-561

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 210-211.

**Decision rationale:** According to the ACOEM Guidelines, surgery for impingement syndrome is not indicated for patients 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 prior to considering surgery. Surgery is noted to be indicated for significant rotator cuff tears that impair activities by causing weakness of arm elevation or rotation and in those who have failed physical therapy. The clinical information submitted for review indicates that an MRI of the left shoulder revealed an intermediate grade intrasubstance tear of the supraspinatus tendon. The patient was also noted to have a positive impingement sign upon physical examination of the left shoulder. However, in his most recent clinical note, the patient's treating physician indicated that he did not complain of left shoulder symptoms, he indicated that physical therapy had helped, and his physical examination findings failed to reveal evidence of weakness of arm elevation or rotation. As the patient was not shown to have symptoms of left shoulder pain or weakness, and he was not shown to have weakness, atrophy, or significant decreased motor strength in any plane of the left shoulder, the request for an arthroscopic subacromial decompression is not supported. The request for a left shoulder arthroscopy with subacromial decompressions is not medically necessary and appropriate.